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HUMAN CAPITAL

Additional Actions Needed to Enhance DOD's Efforts to Address Mental Health Care Stigma

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Why GAO Did This Study

A 2010 DOD task force on suicide prevention concluded that stigma—the negative attitudes and beliefs about mental illness and related care—interferes with willingness to seek mental health care in the military. In August 2012, the President identified mental health care for servicemembers as a high priority. The National Defense Authorization Act for Fiscal Year 2015 included a provision for GAO to assess the perception of the impact of mental health care stigma. This report examines (1) military servicemembers' and deployed civilians' reported perceptions about mental health care stigma; and the extent to which DOD (2) has policies and related efforts to address mental health care stigma and (3) is positioned to measure the progress of its efforts to reduce mental health care stigma.

GAO analyzed program documentation and DOD-wide and service-specific survey results; conducted 23 non-generalizable focus groups with servicemembers and 3 with deployed civilians at six locations representing distinct and dispersed populations; and interviewed DOD and service officials.

What GAO Recommends

GAO is making 7 recommendations, including that DOD collect and monitor deployed civilians' perceptions of mental health care; clarify and update policies contributing to stigma; clearly define barriers to care understood as "stigma," and establish related goals and measures; and designate an entity to coordinate stigma reduction efforts. In written comments on a draft of this report, DOD generally agreed with all 7 recommendations.

View GAO-16-404. For more information, contact Brenda S. Farrell at (202) 512-3604 or farrellb@gao.gov

What GAO Found

Military servicemembers' perceive that a stigma exists with seeking mental health care, but little information is known about Department of Defense (DOD) deployed civilian perceptions. GAO's analysis of the most recently available data from a DOD-wide survey found that about 37 percent of active duty servicemembers in 2011 and 39 percent of reservists in the 2010/2011 timeframe responded that they thought seeking mental health care through the military would probably or definitely damage a person's career. Military service-sponsored surveys and comments from all 26 of GAO's focus groups with servicemembers and with civilian employees of DOD who have deployed or were preparing to deploy also indicated that stigma is a concern. GAO's review of DOD-wide surveys found that none of them measure deployed civilians' perceptions of mental health care, including stigma. As of February 2016, DOD did not have a functional mechanism to identify the population of deployed civilians. DOD officials are taking actions to improve the accuracy of their data on deployed civilians, in response to a prior GAO recommendation in June 2009. Once these data are available, DOD should be in a better position to collect information and monitor deployed civilians perceptions about mental health care. Without this information, DOD cannot fully assess the organizational climate of its total workforce.

DOD has efforts underway to improve perceptions about mental health care for servicemembers and, to a comparably limited extent, deployed civilians, but has not clarified or updated certain policy provisions that may contribute to mental health care stigma. DOD officials and health care providers said that certain policies are unclear or out-of-date and limit career opportunities for individuals who have sought mental health care. A 2014 RAND Corporation report identified 203 DOD policies that may contribute to stigma. For example, an Army policy requires verification that a soldier has no record of emotional or mental instability to be eligible for recruiting duty. This policy is unclear as to what diagnoses constitute instability, and whether a servicemember responding well to treatment would be prohibited from this opportunity. Without clarifications and updates to policies, DOD will be hampered in meeting its policy goal of reducing stigma.

DOD is not well positioned to measure the progress of its mental health care stigma reduction efforts for several reasons. First, DOD has not clearly defined the barriers to care it generally understands as "mental health care stigma" and does not have related goals or performance measures to track progress. Second, GAO's review found that multiple DOD- and service-sponsored surveys that contain questions to gauge stigma use inconsistent methods, which precludes the analysis of trends over time in order to determine effectiveness of stigma reduction efforts. Finally, GAO found that responsibilities for mental health care stigma reduction are dispersed among various organizations within DOD and the services, and some information sharing is hampered. No single entity is coordinating department-wide efforts to reduce stigma. Without a clear definition for "mental healthcare stigma" with goals and measures, along with a coordinating entity to oversee program and policy efforts and data collection and analysis, DOD does not have assurance that its efforts are effective and that resources are most efficiently allocated.

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A 2010 Department of Defense (DOD) Task Force on the Prevention of Suicide by Members of the Armed Forces concluded that servicemembers commonly do not want to enter a behavioral health clinic for care largely because of the stigma and discrimination they experience or expect to experience as a consequence. Further, the task force concluded that stigma can interfere with their willingness to receive mental health care, which could lead to a lethal outcome.[1] The Centers for Disease Control and Prevention (CDC) discusses "stigma" as an attribute that is deeply discrediting and that sets the bearer of that attribute apart from the rest of society, bringing with it feelings of shame and isolation. With respect to mental illness, the CDC reports that negative attitudes often underlie mental health-related stigma, which can cause affected persons to deny symptoms, delay treatment and refrain from daily activities, and is a public health priority. As many DOD civilians deploy in support of missions, and with hundreds of servicemembers committing suicide each year—about as many having not deployed as those who have experienced deployment[2]—DOD has acknowledged that

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[1] Department of Defense, *The Challenge and the Promise: Strengthening the Force, Preventing Suicide and Saving Lives; Final Report of the Department of Defense Task Force on the Prevention of Suicide by Members of the Armed Forces* (August 2010).

[2] Department of Defense, *Department of Defense Suicide Event Report: Calendar Year 2014 Annual Report* (Jan. 13, 2016).

it must move forward to put psychological health and fitness on an equal footing with physical health and fitness.

In August 2012, the President issued Executive Order 13625 to improve access to and awareness of mental health services for veterans, servicemembers, and military families.[3] As part of the executive order's policy directives, an interagency task force on military and veterans mental health was established to evaluate several issues, including agency efforts to improve awareness and reduce stigma for those needing to seek care. Two years later, the RAND Corporation, a nonprofit, nonpartisan research organization, reported that many servicemembers are not regularly seeking needed care when they have mental health symptoms or disorders despite the efforts of both DOD and the Veterans Health Administration to enhance mental health care services.[4] The report also states that without appropriate treatment, mental health symptoms or disorders can have wide-ranging and negative impacts on the quality of life and the social, emotional, and cognitive functioning of affected servicemembers.

The Carl Levin and Howard P. "Buck" McKeon National Defense Authorization Act for Fiscal Year 2015 included a provision for GAO to assess the perception of the impact of the stigma of mental health treatment on the career advancement and retention of members of the armed forces and deployed civilian employees, and assess the policies, procedures and programs, including training and education of the armed forces to reduce such stigma.[5] For this report, we address (1) military servicemembers' and deployed civilians' reported perceptions about mental health care stigma in the military; (2) the extent to which DOD has

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[3] Executive Order 13625, *Improving Access to Mental Health Services for Veterans, Service Members, and Military Families* 77 Fed. Reg.54783 (Sept. 5, 2012).

[4] The RAND Corporation, *Mental Health Stigma in the Military* (2014).

[5] Pub. L. No. 113-291, § 732 (Dec. 19, 2014). The mandate also included a provision for GAO to assess the availability and accessibility of mental health care for members of the Armed Forces and deployed civilian DOD employees. That information will be provided in a separate report on DOD mental health care access issues to be issued in April 2016 (see GAO-16-416 when available). Further, although in times of war or other national emergency, the Coast Guard may operate under the Department of the Navy, it otherwise falls under the control of the Department of Homeland Security. The Coast Guard has established its own policies to address mental health care stigma reduction. Therefore, for the purposes of this report, we did not include the Coast Guard in our review of DOD efforts to reduce mental health care stigma.

policies and related efforts to address mental health care stigma among servicemembers and deployed civilians, including for personnel who have access to classified information; and (3) the extent to which DOD is positioned to measure the progress of its efforts to reduce mental health care stigma.

To address our first objective, we reviewed six DOD-wide and service-sponsored surveys that contained specific questions related to barriers to seeking mental health care, including perceptions of stigma.[6] For the 2011 Health Related Behaviors Survey of Active Duty Military Personnel and the 2010-2011 Health Related Behaviors Reserve Component Survey, we obtained data from DOD for the survey questions related to stigma and conducted a weighted analysis for stratified categories of interest. We determined that the surveys were sufficiently reliable for estimating the perceptions of stigma at individual snapshots in time. For the Defense Equal Opportunity Management Institute (DEOMI) Organizational Climate Surveys for 2015; the 2013 and 2012 Mental Health Advisory Team (MHAT) Studies (MHAT-9 and Joint MHAT-8); the 2013 Air Force Community Assessment Surveys for Active Duty, Air Force Reserve, and Air National Guard; and the 2014 Status of Forces Survey of Active Duty Members, we reviewed the related reports for relevancy by evaluating the questions and target populations and found that they all contained questions relevant to mental health care stigma. We also reviewed reports of the methodology and any limitations and findings of the MHAT-9 and Joint MHAT-8 and the 2013 Air Force Community Assessment Surveys and found them to be sufficiently reliable sources for estimates of perceived stigma. We used these surveys to determine the perception that stigma exists in respondents at various points in time as measured by each survey.

In addition to our review of the DOD- and service-sponsored surveys, we conducted focus groups with a non-generalizable sample of

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[6] The surveys that we identified and determined to have stigma-related questions were (1) the 2011 Health Related Behaviors Survey of Active Duty Military Personnel; (2) the 2010-2011 Health Related Behaviors Reserve Component Survey; (3) the Defense Equal Opportunity Management Institute (DEOMI) Organizational Climate Surveys for 2015; (4) the 2013 and 2012 Mental Health Advisory Team (MHAT) Studies (MHAT-9 and Joint MHAT-8); (5) The 2013 Air Force Community Assessment Surveys for Active Duty, Air Force Reserve, and Air National Guard; and (6) the 2014 Status of Forces Survey of Active Duty Members. Further details on our analysis of these surveys are presented in appendix I.

servicemembers and deployed civilians to get their perspectives on career impacts of seeking mental health care, command and leadership levels of support of those seeking care, and possible mental health resources.[7] To do so, we selected four geographically dispersed installations—one for each of the four services — and conducted 23 focus groups, organized by rank and rate of active duty military personnel. Additionally, we conducted three focus groups at two other locations with DOD federal civilian employees who had deployed in the past or were training to deploy. The information that we obtained during these focus groups accurately captures the opinions provided by the servicemembers and DOD federal civilian employees who attended the focus groups at the six locations we visited. However, these opinions cannot be generalized to all servicemembers or DOD civilians at these locations or to all servicemembers or DOD civilians across the department. We also conducted interviews with servicemembers, unit leaders, clinical and non-clinical providers, and other officials at each of the locations visited. We compared information we gathered from our survey reviews, focus groups, and interviews with DOD's *Diversity and Inclusion Strategic Plan for 2012-2017* which states that the department should ensure a framework to oversee and monitor organizational climate.[8] Additionally, we used the *Standards for Internal Control in the Federal Government*,[9] which requires management to use quality information to inform decisions and evaluate performance in achieving key objectives, to assess the extent to which DOD had collected and monitored servicemembers' and deployed civilians' perceptions of stigma associated with seeking mental health care.

For our second objective, we identified White House guidance[10] and a cross-agency priority goal established by the Office of Management and

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[7] For purposes of this report, the term deployed civilians refers to federal civilian employees of the Department of Defense who are organized, trained, cleared, equipped, and ready to deploy in support of combat operations by the military, contingencies; emergency operations; humanitarian missions, disaster relief; restoration of order; drug interdiction; and stability operations. Collectively, this set of DOD federal civilian employees is known as the DOD Civilian Expeditionary Workforce.

[8] Department of Defense, *Diversity and Inclusion Strategic Plan 2012-2017* (2012).

[9] GAO, *Standards for Internal Control in the Federal Government*, GAO-14-704G (Washington, D.C.: September 2014).

[10] Executive Order No.13625, *Improving Access to Mental Health Services for Veterans, Service Members, and Military Families*, 77 Fed. Reg. 54783 (Sept. 5, 2012).

Budget to improve mental health outcomes for veterans, servicemembers, and their families.[11] Additionally, we identified within the *Standards of Internal Control in the Federal Government* the importance of having clear, updated policies that align with an organization's missions and goals.[12] We applied these standards to DOD's goals for stigma reduction and inclusiveness. Through literature searches and interviews with DOD and service officials, we identified DOD-level and service-level policies, memoranda, and other information to determine what efforts exist, including training and education, for reducing mental health care stigma for both military and civilian personnel. We used information from our interviews and focus groups to identify policies that officials believed to be adding to the existence of stigma, may contain restrictive language, or may be based on out-of-date information. Additionally, we supplemented and corroborated our testimonial evidence from our interviews with the 2014 RAND Corporation report, *Mental Health Stigma in the Military*,[13] and concluded that the report was sufficiently reliable for using the report's conclusions and recommendations a part of our report. We also obtained and reviewed DOD's policies on issuing, suspending, and revoking personnel security clearances and interviewed officials from the Office of the Under Secretary of Defense for Intelligence, the DOD Consolidated Adjudications Facility, the Defense Office of Hearings and Appeals, and security managers at each of the installations we visited to determine their interpretations of the policies as well as any local implementation practices related to the management of personnel security clearances.

For our third objective, we used the surveys and stigma related questions, DOD and service level policies, and DOD task force and other reports identified in the first two objectives and reviewed them for the existence of definitions of stigma, goals associated with any efforts to address stigma, and any performance measures related to those goals. We assessed this information against government performance and management practices

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[11] Office of Management and Budget, Cross-Agency Priority Goals (March 2014). Cross-agency priority goals are outcome-oriented goals covering a limited number of crosscutting policy areas and management improvements across the Federal Government in areas of information technology, financial management, human resources, and real property.

[12] GAO-14-704G.

[13] The RAND Corporation, *Mental Health Stigma in the Military* (2014).

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that state that agencies should establish performance goals in an objective, quantifiable and measurable form, and that they should be defined with sufficient precision to permit ready assessment of progress in meeting that goal.[14] Additionally, we used the *Standards for Internal Control in the Federal Government* which states that an agency's management should define objectives clearly and that agencies should allow for the assessment of performance toward achieving objectives. We also reviewed the methodologies and administration of the surveys we identified and selected which had stigma-related questions against federal standards for statistical surveys that require the use of consistent data collection procedures in order to maintain a consistent data series over time.[15] Further, we identified through a literature review and interviews the DOD- and service-level offices and organizations that have either direct responsibilities for reducing stigma specified in policies or in their mission statements or are involved in addressing stigma as a collateral function even if not charged with such responsibilities directly. We compared our results with the *Standards for Internal Control in the Federal Government* which requires the assignment of responsibility and delegation of authority to achieve agency objectives as an effective internal control. To corroborate our understanding of the roles and missions of each of the organizations we identified as being involved in mental health stigma related efforts, we conducted interviews with officials within DOD and the services.

We conducted this performance audit from June 2015 to April 2016 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives. Further details on our overall scope and methodology are presented in appendix I, and the specific methodology for and the results from our focus groups are presented in appendix II.

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[14] Government Performance and Results Modernization Act of 2010, Pub. L. No. 111-352 (Jan.2, 2011).

[15] Office of Management and Budget, *Standards and Guidelines for Statistical Surveys* (September 2006).

Background

DOD Entities with Oversight or Management Responsibilities Related to Mental Health Care

Various entities within the Office of the Under Secretary of Defense for Personnel and Readiness (USD (P&R)) as well as within the military services have responsibilities related to the oversight or implementation of programs designed to address military and civilian personnel mental health issues.

The USD (P&R) is the principal staff advisor to the Secretary of Defense for Total Force Management as it relates to readiness, National Guard and reserve component affairs, health affairs, training, and personnel requirements and management, including equal opportunity, morale, welfare, recreation and quality-of-life matters. For matters related to security clearance procedures and other intelligence issues, the Under Secretary of Defense for Intelligence develops, oversees, and coordinates policies, programs, and guidance for DOD's personnel security program.

Reporting to the USD (P&R) is the Assistant Secretary of Defense for Health Affairs (ASD (HA)) who serves as the principal advisor to the Secretary of Defense for all DOD force health protection policies, programs, and activities. The ASD (HA) oversees the development of medical policies, analyses, and recommendations to the Secretary of Defense and the USD (P&R) and issues guidance to DOD components on medical matters. Additionally, the ASD (HA) oversees the Defense Health Agency, which among other things provides administrative support for the services' respective medical programs, combining common "shared" services. The Director, Defense Health Agency promotes combat operational stress initiatives that reduce stigma associated with seeking mental health care.

The Defense Centers of Excellence (DCOE) for Psychological Health and Traumatic Brain Injury became part of the Defense Health Agency as of February 2016.[16] The DCOE assesses, validates, oversees and facilitates

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[16] The Defense Centers of Excellence (DCOE) for Psychological Health and Traumatic Brain Injury was established by the National Defense Authorization Act for Fiscal Year 2008 to create centers of excellence on traumatic brain injuries and post-traumatic stress disorder and other psychological health conditions to develop excellence in prevention, outreach, and care for those with these conditions. Pub. L. No. 110-181, §§ 1621 & 1622 (Jan. 28, 2008).

prevention, resilience, identification, treatment, outreach, rehabilitation, and reintegration programs for psychological health and traumatic brain injury. Moreover, the fiscal year 2016 Defense Health Program budget request states that DCOE also seeks to mitigate the stigma that still deters some from reaching out for help for problems such as post-traumatic stress disorder or traumatic brain injury.

Additionally, the Defense Suicide Prevention Office reports through the Executive Director of the Office of Force Resiliency to the USD (P&R). It develops and implements a comprehensive strategic communication plan with guidance to promote suicide prevention and messaging to all levels, in collaboration with the military departments, to, among other things, reduce stigma for seeking behavioral health care.

The Secretaries of the military services are responsible for holding commanders accountable for implementing DOD's policy to foster a culture of support in the provision of mental health care in order to dispel the stigma of seeking mental health care education services. Within the military health system, each of the Army, the Navy, and the Air Force provides mental or behavioral health services to deliver a range of clinical psychological services to servicemembers.[17] Additionally, other resources are available outside the military health system such as chaplain services, contracted counseling services off base, and peer support programs.

Reports and Studies Related to Mental Health Care Stigma Issued by DOD and Other Organizations

Over the last decade, DOD and other organizations have issued the following reports and studies associated with mental health care stigma. For more information about these reports, see appendix III.

- **2007 DOD Task Force on Mental Health** – This report states that maintaining psychological health, among other things, is essential to maintaining a ready and fully capable military force; however, stigma in the military remains pervasive and often prevents servicemembers from seeking needed care.[18]

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[17] The Navy provides medical services, to include mental health care services, to the Marine Corps.

[18] Department of Defense, Task Force on Mental Health, *An Achievable Vision: Report of the Department of Defense Task Force on Mental Health* (2007).

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- **2008 RAND Corporation Study: Invisible Wounds of War: Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recovery** – This study addresses, among other things, gaps in knowledge about the mental health and cognitive needs of servicemembers returning from Afghanistan and Iraq, the adequacy of the care systems available to meet those needs, and factors, such as stigma, related to whether and how injured servicemembers and veterans seek care.[19]

- **2010 DOD Task Force on the Prevention of Suicide by Members of the Armed Forces** – The final report of this task force—mandated by Congress[20]—includes 76 targeted recommendations, including developing a comprehensive stigma reduction campaign plan that attacks the issue of suicide prevention on multiple fronts to encourage help-seeking behavior and normalizes the care incurred by servicemembers.[21]

- **2011 RAND Corporation Study: Promoting Psychological Resilience in the U.S. Military** – This study states that without strong leadership, military resilience programs—designed to help encourage and support servicemembers in their capacity to adapt successful to risk and adversity—cannot be successful, because leadership can play a pivotal role in creating a command climate in which it is okay to get help for psychological health concerns. However, current policy could promote cultural attitudes and beliefs that inhibit acknowledging problems and seeking mental health care. [22]

- **2013 Institute of Medicine of the National Academies report** - This report states, among other things, that stigma is a problem for military personnel receiving care or seeking care for mental health or

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[19] The RAND Corporation, *Invisible Wounds of War: Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recovery* (2008).

[20] Duncan Hunter National Defense Authorization Act for Fiscal Year 2009, Pub. L. No. 110-417, div. A, § 733 (Oct. 14, 2008).

[21] Department of Defense, *The Challenge and the Promise: Strengthening the Force, Preventing Suicide and Saving Lives; Final Report of the Department of Defense Task Force on the Prevention of Suicide by Members of the Armed Forces* (August 2010).

[22] The RAND Corporation, *Promoting Psychological Resilience in the U.S. Military* (2011).

substance abuse problems.[23] According to this report, active duty servicemembers fear that visiting a mental health care provider will jeopardize their careers because of the military's long-standing policy of reporting these types of problems through the chain of command.

- **2014 RAND Corporation report: Mental Health Stigma in the Military -** This report contains six findings from the content analysis of DOD policies, including identifying policies that may expose servicemembers to stigma or discrimination because they allow non–mental health professionals to determine mental health fitness. [24]

Deployed DOD Federal Civilian Employees

The structure of the armed forces is based on the Total Force concept, which recognizes that all personnel working for DOD—active duty military personnel, reservists, defense contractors, host nation military and civilian personnel, and DOD federal civilian employees—contribute to national defense. DOD relies on the federal civilian employees it deploys to support a range of essential missions, including intelligence collection, criminal investigations, and weapon systems acquisition and maintenance. They serve in a variety of positions, provide essential capabilities and, where appropriate for civilians to do so, support mission requirements such as combat, contingencies, emergency operations; humanitarian and civic assistance activities; disaster relief; restoration of order; drug interdiction; and stability operations of DOD, collectively referred to as "expeditionary requirements." DOD deploys these federal civilian expeditionary employees voluntarily or involuntarily to accomplish its mission.

In an effort to protect the health of deployed DOD civilian employees and to medically assess DOD civilian employees who serve expeditionary requirements, DOD requires these employees to have an annual health assessment to determine whether the employee is available for worldwide deployment. It also requires pre- and post-deployment health assessments to be completed. Additionally, DOD civilian employees who become ill, contract diseases, or who are injured or wounded while deployed in support of U.S. military forces engaged in hostilities are

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[23] Institute of Medicine of the National Academies, *Returning Home from Iraq and Afghanistan: Assessment of Readjustment Needs of Veterans, Service Members, and Their Families* (Washington, D.C.: 2013).

[24] The RAND Corporation, *Mental Health Stigma in the Military* (2014).

eligible for medical evacuation and health care treatment and services in military treatment facilities at no cost to the civilian employee and at the same level and scope, including mental health care services, provided to military personnel. Deployed DOD civilian employees who were treated while deployed in theater continue to be eligible for treatment in a military treatment facility or in a civilian medical facility for compensable illnesses, diseases, wounds, or injuries[25] upon their return at no cost to the civilian employee. Further, DOD civilian employees who were deployed and are subsequently determined to have compensable illnesses, diseases, wounds, or injuries are also eligible for treatment in a military treatment facility or civilian sector medical facility at no cost to the civilian employee.

Military Servicemembers Report the Perception of Stigma Related to Seeking Mental Health Care but Little Is Known about Deployed DOD Civilians' Perceptions

Military Servicemembers Report the Perception of Stigma Related to Seeking Mental Health Care

Results of surveys and studies sponsored by DOD and the military services conducted periodically between 2010 and 2015 show that servicemembers in the active and reserve components believe there is a stigma associated with seeking mental health care in the military.

Based on results from the most recently completed department-wide Health Related Behaviors Survey of active component servicemembers in 2011, we found that an estimated 37 percent of active duty

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[25] As defined in the Department of Labor Office of Workers' Compensation Program. 5 U.S.C. §§ 8101 – 8173. Additionally, Under the Federal Employees' Compensation Act, any disability resulting from a war-risk hazard is generally deemed to have resulted from personal injury sustained while in the performance of duty.

servicemembers thought that seeking counseling or mental health care treatment through the military would probably or definitely damage a person's military career.[26] Among active duty servicemembers who have sought mental health care through the military, an estimated 22 percent believed their career was affected somewhat negatively or very negatively because they sought counseling or mental health care treatment. In table 1, we summarize the survey results regarding active duty servicemembers' (enlisted personnel's and officers') perceptions of the effect of seeking mental health care on a servicemember's career.

Table 1: Survey Estimates Regarding Active Component Servicemembers' Perceived Effect of Seeking Mental Health Care on a Servicemember's Career

	Percentage of servicemembers who believe seeking counseling or mental health care through the military would probably or definitely damage a person's military career			Percentage of servicemembers who have sought mental health care through the military and believe their career was affected somewhat negatively or very negatively		
	Total	**Enlisted**	**Officer**	**Total**	**Enlisted**	**Officer**
Army	**37%**	38%	35%	**21%**	21%	18%
Navy	**42**	42	42	**24**	25	21
Marine Corps	**38**	38	38	**26**	26	27
Air Force	**34**	34	37	**18**	18	19
All Servicemembers	**37%**	37%	38%	**22%**	22%	20%

Source: GAO analysis of the Department of Defense's 2011 Health Related Behaviors Survey of active component servicemembers. | GAO-16-404

Notes: Margins of error for these estimates are all within +/-10 percentage points.

Based on data from the 2010-2011 Health Related Behaviors Survey of reserve component servicemembers,[27] we estimated that 39 percent of reserve component servicemembers reported the perception that seeking counseling or mental health care through the military would probably or

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[26] Department of Defense, *2011 Health Related Behaviors Survey of Active Duty Military Personnel*, ICF International (Fairfax, VA:, February 2013). This is the most recently completed Health Related Behaviors survey of the active component. The next iteration of the active component survey opened to participants in September 2015, but data collection and analysis is not yet complete.

[27] Department of Defense, Defense Lifestyle Assessment Program (DLAP) *2010-2011 Department of Defense Health Related Behaviors Reserve Component Survey* RTI International (July 2012).

definitely damage a person's military career.[28] Further, approximately 14 percent of reserve component servicemembers reported that they did not believe their chain of command was supportive of personnel seeking mental health care services when needed. In table 2, we summarize the survey results regarding reserve component servicemembers' (enlisted personnel's and officers') perceptions of the effect of seeking mental health care on a servicemember's career.

Table 2: Survey Estimates Regarding Reserve Component Servicemembers' Perceptions of the Effect of Seeking Mental Health Care on a Servicemember's Career

	Percentage of reservists who believe seeking counseling or mental health care through the military would probably or definitely damage a person's military career			Percentage of reservists who believe their chain of command is not supportive of personnel seeking mental health services when needed		
	Total	**Enlisted**	**Officer**	**Total**	**Enlisted**	**Officer**
Army National Guard (ARNG)	**38%**	38%	40%	**16%**	17%	8%
Army Reserve (USAR)	**36**	35	39	**16**	17	12
Naval Reserve (USNR)	**39**	39	40	**10**	12	6
Air National Guard (ANG)	**46**	46	48	**12**	12	11
Air Force Reserve (USAFR)	**47**	45	51	**12**	12	10
Marine Corps Reserve (USMCR)	**35**	36	32	**14**	15	2
All Reservists	**39%**	**39%**	**42%**	**14%**	**15%**	**10%**

Source: GAO analysis of 2010-2011 Health Related Behaviors Reserve Component Survey. | GAO-16-404

Notes: The 2010-2011 Reserve Component Health Related Behaviors Survey was released within the department only and was not publicly released by DOD because DOD determined there were critical deficiencies in the draft report, which was prepared by an outside contractor. According to DOD, the draft lacked multi-comparison statistics, failed to account for updated national health goal targets and neglected to include a sufficiently up-to-date and comprehensive review of the literature. However, these DOD officials believe the data is sufficient for use in our review, and our review of the data and report found it to be reliable for providing an analysis of the responses to the mental health care stigma-related questions to estimate the perception of stigma at various snapshots in time.

Margins of error for these estimates are all within +/-10 percentage points, except for Marine Corps Reserve Officer responses regarding whether seeking mental health care would damage a person's career, which had a margin of error of +/- 13 percentage points.

[28] DOD conducted another iteration of the Reserve Component Health Related Behaviors survey in 2014, and officials told us that data collection was completed in early 2015. However, the results of that effort are still under review and the agency could not authorize release of the findings in time for our review.

Our interviews with officials from various organizations within the Office of the Secretary of Defense (OSD), the military service commands, and selected installations and focus groups with servicemembers also revealed that mental health care stigma is a concern. Specifically, in 42 of 50 interviews, officials mentioned that they believe a stigma exists with seeking mental health care in the military. Additionally, participants in 22 out of 23 active duty servicemember focus groups we conducted stated that they believe a stigma exists with seeking mental health care in the military. In 8 of the 23 groups, all servicemembers stated that they perceive that mental health care stigma exists in the military. Moreover, participants in all 23 focus groups with active duty servicemembers had concerns about the likelihood that seeking mental health care could negatively affect their career because of the associated stigma. Some of the most prevalent specific concerns included (1) being associated with "malingering;"[29] (2) possibly losing job qualifications such as a security clearance or the ability to carry a weapon; and (3) having to live up to the competitive military image. One participant described their concerns this way: "Mental health [care] is perceived as crazy…[it] is called 'the wizard' so that's evidence of the stigma. They take away your shoe laces, your belt. That's the stigma of what going to see 'the wizard' is." At another installation, participants shared that the mental health clinic is accessed only by a single elevator, so it is known that anyone waiting for that elevator needs to be seen by the mental health care staff for some reason. One participant called it the "elevator of shame," and another noted that "people don't want to ask where it is, so they'll wander around."

Through their own separate studies, the military services have also concluded that stigma is a significant concern. For example, the Army and Marine Corps reported in surveys used in the Mental Health Advisory Team Studies in 2013 that soldiers and marines in combat settings who screen positive for mental health problems on a survey instrument report greater stigma than those who do not screen positive.[30] Specifically, of

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[29] Malingering is defined as feigning illness, physical disablement, mental lapse or derangement, or intentionally inflicting self-injury for the purpose of avoiding work, duty or service. Malingering is punishable as a court-martial may direct. 10 U.S.C. § 915.

[30] Office of the Surgeon General, US Army Medical Command, *Mental Health Advisory Team 9 (MHAT 9) Operation Enduring Freedom (OEF) 2013 Afghanistan,* (October 10, 2013); Office of the Surgeon General, US Army Medical Command, *Joint Mental Health Advisory Team 8 (J-MHAT 8) Operation Enduring Freedom 2012 Afghanistan,* (August 12, 2013).The survey used in the MHAT screens respondents for mental health problems, including acute stress, depression and anxiety.

the soldiers and marines surveyed, 49 percent and 60 percent respectively of those who screen positive for mental health problems reported that concerns about being seen as weak affected their decision to receive mental health services, as opposed to 24 percent and 28 percent respectively of those who did not screen positive for mental health problems. For more information about these and other studies, see appendix III.

DOD Has Limited Information about Deployed Civilians' Perceptions of Stigma Associated with Mental Health Care

Our review of department-wide survey instruments and interviews with officials found that there are no surveys that specifically measure the perceptions of deployed DOD civilian personnel about mental health care, including stigma. In all three focus groups we conducted with civilian employees of DOD who have deployed or were preparing to deploy, participants reported that they believe a stigma exists with seeking mental health care. For example, participants stated that they had concerns about the likelihood that treatment could negatively affect their career as well as concerns about being harassed by peers for appearing weak. One participant stated that, "mental health is viewed as a weakness to supervisors," while another characterized concern about negative career effects by stating that "If they knew you were going to mental health, that's a career ender as far as progression. They'll stop giving you the good assignments." Some additional specific concerns discussed included the possibility of losing required job qualifications, such as the loss of a security clearance, and the possible negative impact on career advancement opportunities.

As previously mentioned, in an effort to protect the health of deployed DOD civilians and to medically assess DOD civilian employees who serve expeditionary requirements, DOD requires these civilians to complete the pre- and post-deployment health assessments, which contain questions related to psychological health, but do not gauge perceptions about mental health care. Officials from the Office of the Deputy Assistant Secretary of Defense for Civilian Personnel Policy (DASD (CPP)) stated that they are not aware of any other survey instruments or other studies within DOD that assess civilians' perceptions about mental health care.

In order to retain a talented workforce that can meet its 21st century readiness goals, DOD's *Diversity and Inclusion Strategic Plan for 2012-2017* states that the department should ensure a framework to oversee

and monitor organizational climate.[31] Further, federal internal control standards require the use of quality information that is appropriate, current, complete, accurate, accessible and timely to inform decisions and evaluate performance in achieving key objectives, such as DOD's goal to monitor the organizational climate of its total workforce, including deployed civilians. [32] However, DOD does not currently have a single automated mechanism to identify the population of deployed DOD civilians. By one DOD estimate, the number of deployed DOD civilians reached a total of about 41,000 from 2001 to 2010.[33] Furthermore, DOD officials we spoke with provided two reasons that the department has not yet collected information about civilian workforce climate in general, or deployed DOD civilians in particular, including perceptions about mental health care. First, they stated that it is difficult to survey the population of civilians due to requirements for a personnel security clearance from the Office of Management and Budget and other restrictions. Second, collecting and monitoring the perceptions of civilians related to mental health care has not been a DOD priority.

Because of the importance of identifying and accounting for its deployed civilian employees, DOD established the Civilian Expeditionary Workforce in 2009 to create a ready cadre of civilians to respond to urgent expeditionary requirements, and directed its component leaders to establish procedures to account for civilian employees in theaters of operations.[34] However, we reported in June 2009 that DOD was unable to provide the total number of DOD civilians deployed to Iraq, Afghanistan, or other locations that supported operations in this region.[35] Therefore, we recommended that DOD establish mechanisms to ensure that the department's policies to identify and track deployed civilians are

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[31] Department of Defense, *Diversity and Inclusion Strategic Plan 2012-2017* (2012).

[32] GAO-14-704G.

[33] Deputy Under Secretary of Defense (Civilian Personnel Policy), *Report to Congress: Medical Care for Department of Defense and Non-Department of Defense Federal Civilians Injured or Wounded in Support of Contingency Operations*.

[34] Department of Defense Directive 1404.10, *DOD Civilian Expeditionary Workforce*, (Jan. 23, 2008); Department of Defense Instruction 1400.32, *DOD Civilian Work Force Contingency and Emergency Planning Guidelines and Procedures* (Apr. 24, 1995).

[35] GAO, *Human Capital: Actions Needed to Better Track and Provide Timely and Accurate Compensation and Medical Benefits to Deployed Federal Civilians*, GAO-09-562 (Washington, D.C.: June 26, 2009).

implemented, and DOD later introduced an application that was to provide near real-time personnel reporting through the use of existing service specific deployment systems to maintain a civilian deployment file. A DOD official told us that data quality checks showed the file to have serious issues, and it was last produced in January 2015. Officials stated they are in the process of revisions and estimate June 2016 as the earliest possible date they would be able to report information on deployed civilians again. As a result, DOD officials we spoke with from the Office of the DASD (CPP) were not able to identify the number of currently deployed DOD civilians nor an estimated number of those deployed in past years, stating that such estimation would require the collection of data from multiple sources across the department.

Given that deployed civilians often serve side-by-side with servicemembers in support of DOD contingency operations and must undergo the same pre- and post-deployment health assessments as their military counterparts, it is important for DOD to collect and monitor its civilian personnel perceptions regarding mental health care or other issues that affect morale and well-being. Without doing so, DOD cannot assess the organizational climate of its total workforce, and, further, DOD may be challenged to meet its goals for retaining top civilian employees and recruiting individuals for future deployment.

DOD Has Efforts Underway to Servicemembers' and Deployed Civilians' Perceptions about Mental Health Care, but Has Not Clarified or Updated Certain Policy Provisions That May Contribute to Stigma

DOD has efforts in place to improve servicemembers' and deployed DOD civilians' perceptions about mental health care and thereby address the stigma associated with seeking help for mental health-related issues, including stigma. However, DOD and the services have certain policies that are unclear and not up-to-date, and may contribute to the stigma of mental health care. Further, DOD has not clarified and updated its policy on grounds for suspension of access to classified information or removal from sensitive positions based on mental health information.

DOD Has Efforts Underway to Improve Perceptions about Mental Health Care among Servicemembers and to a Comparatively Limited Extent among Deployed Civilians

The White House declared by a 2012 executive order that mental health care for servicemembers is a top priority.[36] Two years later, the Office of Management and Budget established as a cross-agency priority goal the improvement of mental health outcomes for service members, veterans, and their families.[37] Specifically, the goal calls for the reduction of barriers to seeking mental health care and support by identifying, expanding, and promoting programs, initiatives, and efforts to reduce negative perceptions.[38] To that end, DOD has taken steps to reduce stigma as a barrier to mental health care and improve perceptions about care across the active and reserve components of the military services to target servicemembers and, to a lesser extent, deployed civilian personnel.

Based on our analysis of program documentation, DOD reports, and interviews with DOD and service officials, we found that the department's stigma reduction efforts are aimed toward changing the military culture and generally align with three approaches:

- ***Programs and campaigns to change perceptions.*** DOD and the services have implemented programs and awareness campaigns for active and reserve component servicemembers that address stigma by emphasizing skills to cultivate personal resilience, including mental health coping and awareness skills, and encouraging help-seeking behavior through the training and education that communicates the benefits of mental health care and dispels myths. For example, DOD implemented the Real Warriors campaign in 2009 to reduce stigma through multimedia outreach about the benefits of help-seeking, featuring personal stories of successful outcomes from treatment.

- ***Clinical and non-clinical treatment initiatives.*** DOD adopted initiatives that officials told us will reduce stigma by making mental health care more accessible, private, and routine. These initiatives include embedding mental health providers within some units of each active component; integrating mental health care in primary care

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[36] Executive Order No. 13625, *Improving Access to Mental Health Services for Veterans, Service Members, and Military Families*, 77 Fed. Reg. 54783 (Sept. 5, 2012).

[37] Office of Management and Budget, *Cross-Agency Priority Goals* (March 2014).

[38] Other barriers to mental health care include, but are not limited to, the availability of services, knowledge about where to get help, the ease of scheduling an appointment and having the time off from work to seek care.

settings of military treatment facilities; and ensuring the widespread availability of nonmedical counseling to provide alternative methods of assistance outside the clinical environment.

- ***Incorporation of stigma reduction goals into policy and guidance.*** From a review of DOD and service policies and guidance for health and fitness and suicide prevention, we identified 13 that declare stigma reduction as a goal, encourage early treatment-seeking, or instruct leaders to advocate for treatment as a sign of strength. DOD commissioned a 2014 RAND Corporation report that found of the 444 policies identified as being related to stigma; 121 of those policies may contribute to stigma reduction.[39]

DOD and the Services Have Not Clarified or Updated Certain Policies That May Contribute to Mental Health Care Stigma in the Military

Based on our interviews with military healthcare providers and our review of several DOD-sponsored reports, we found that providers and reporting entities believe DOD and the services have not clarified or updated certain policies with provisions that may contribute to mental health care stigma in the military, including policies for deployment and career qualifications. At the four selected active duty installations we visited, health care providers from all three military departments stated that certain policies are unclear and too limiting for some individuals who have sought mental health care, which likely contributes to stigma. Some providers explained to us that they believe some DOD policies for career and deployment qualifications have not been updated to reflect improvements in their ability to treat and stabilize servicemembers with mental health conditions. For example, providers at one location cited policies outlining deployment eligibility for the U.S. Central Command[40] and U.S. Africa Command[41] areas of responsibility, which contain provisions that either disqualify or require waivers for individuals who have received a mental or behavioral health diagnosis or a prescription

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[39] Of the DOD policies that were searchable and accessible, the RAND Corporation identified 444 policies that may either reduce or contribute to the stigma of seeking mental health care. Policies that may contribute to stigma are discussed later in this report. The RAND Corporation, *Mental Health Stigma in the Military* (2014).

[40] U.S. Central Command Policy*, PPG-Tab A: Amplification of the Minimal Standards of Fitness for Deployment to the CENTCOM AOR; To Accompany Mod Twelve to USCENTCOM Individual Protection and Individual/Unit Deployment Policy* (Dec. 2, 2013).

[41] U.S. Africa Command MEDGUIDE-1, *Force Health Protection Requirements and Medical Guidance for Entry into the U.S. Africa Command (AFRICOM) Theater* (Sept. 11, 2014).

medication. The Army's policy on the assignment of personnel to its recruiting command was also cited by providers because it includes a provision that precludes eligibility for recruiting duty for individuals who have a history of "emotional or mental instability."[42] As reported by the RAND Corporation in 2014, the Army's recruiting duty policy is unclear as to what diagnoses constitute instability, and whether a servicemember responding well to treatment would be prohibited from this opportunity.[43] Additionally, participants in 21 of our 23 focus groups with servicemembers commented that the possibility of losing career qualifications is a reason that servicemembers may be reluctant to seek mental health care

Concerns about certain DOD policies that may contribute to mental health care stigma have been long-standing issues identified in DOD-sponsored studies about mental health and suicide prevention. These studies have linked such policies with prevalent beliefs among servicemembers that mental health care will end or limit their careers in the military, and they recommended clarifications and updates. For example, in 2007 the DOD Task Force on Mental Health reported that revisions to command notification policies were necessary to combat stigma caused by perceptions that mental health care services are costly to career progression.[44] More recently, in 2013 the Institute of Medicine of the National Academies recommended that DOD review its policies on mental health care with regard to confidentiality and the relationship between treatment-seeking and career advancement due to servicemembers' fears that seeking mental health care will jeopardize their career.[45] The same year, a review by the Navy's Bureau of Medicine and Surgery[46] found a number of policies to be stigmatizing toward

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[42] Army Regulation 601-1, *Assignment of Enlisted Personnel to the U.S. Army Recruiting Command* (Sept. 6, 2011).

[43] The RAND Corporation, *Mental Health Stigma in the Military* (2014)

[44] Department of Defense, *An Achievable Vision: Report of the Department of Defense Task Force on Mental Health* (2007).

[45] Institute of Medicine of the National Academies, *Returning Home from Iraq and Afghanistan: Assessment of Readjustment Needs of Veterans, Service Members, and Their Families* (Washington, D.C.: 2013).

[46] Navy Bureau of Medicine and Surgery, *A Report to the Clinical Standards Board on the Review of Restrictive Policies for Service Members Seeking Mental Health Treatment* (September 2013).

individuals seeking mental health care, such as instructions on the medical qualifications for sailors and marines contained in the *Manual of the Medical Department.*[47]

Similarly, the 2014 report by the RAND Corporation identified 203 policies across the department that may contribute to stigma among servicemembers.[48] The RAND Corporation report found that 14 of the 203 policies reinforce stereotypes through the use of negative terminology such as "acting out" and "temper tantrums," or being prone to dangerous or violent behavior. According to the report, other policies contribute to stigma by, for example, restricting service members with mental health disorders from serving in certain positions. DOD officials told us that such duty restrictions may be necessary, but in 2013 the Navy Bureau of Medicine and Surgery recommended that policies on duty restrictions should be based on the degree of a person's functional impairment rather than the type of diagnosis.[49] Among other things, the RAND Corporation recommended that DOD consider revising (1) policies that use negative terminology and reinforced stereotypes, (2) policies that allow nonprofessionals to determine mental health fitness and that support the use of mandated mental health screening for specific individuals or groups, and (3) policies concerning mental health screening and evaluation programs to ensure that they promote positive attitudes toward treatment-seeking.

We found that the department has made some efforts to make clarifications and updates related to mental health and mental health care. For example, DOD revised its policy on command notification requirements to help address the ongoing challenge of appropriately balancing the need to reduce mental health care stigma, support members' privacy, and encourage help-seeking with the protection of mission readiness and servicemembers' safety.[50] However, during our

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[47] Navy of Bureau of Medicine and Surgery, NAVMED P-1179, *Manual of the Medical Department* (2012).

[48] The RAND Corporation, *Mental Health Stigma in the Military* (2014).

[49] Navy Bureau of Medicine and Surgery, *A Report to the Clinical Standards Board on the Review of Restrictive Policies for Service Members Seeking Mental Health Treatment* (September 2013).

[50] Department of Defense Instruction 6490.08, *Command Notification Requirements to Dispel Stigma in Providing Mental Health Care to Servicemembers* (Aug. 17, 2011).

interviews with officials from the Office of the ASD (HA) and DCOE, those officials stated that there has not been a systematic effort to date that they are aware of to leverage the 2014 RAND Corporation report's recommendation to conduct a department-wide review and revision of stigmatizing policy provisions. Officials acknowledged that a department-wide review of such policies with appropriate updates and clarifications, aligned with this specific recommendation by RAND Corporation, would be valuable for advancing DOD's goal of reducing mental health care stigma.

Federal internal control standards emphasize the importance of having clear, updated policies that align with an organization's mission and goals, which would apply to DOD's goals for stigma reduction and inclusiveness.[51] Further, in its *Diversity and Inclusion Strategic Plan 2012 - 2017*, DOD established that it would promote an inclusive environment that empowers employees to perform at their maximum potential, and committed to analyzing workforce data and policies to ensure full access to developmental assignment opportunities. While the military services are allowed to use attributes such as age and physical and psychological fitness for limiting eligibility for some positions, DOD also recognizes in this strategic plan the importance of diversity as a critical imperative for mission readiness and accomplishment.[52]

In discussing reasons that such a department-wide review of policies had not yet been undertaken since the issuance of the 2014 RAND Corporation report, DOD officials described two contributing factors. First, other competing priorities have prevented DOD and the services from advancing this effort to date. Second, different DOD components and offices are responsible for the policies identified and for initiating changes. Without a department-wide policy review, leveraging the 2014 RAND Corporation report's recommendations where appropriate and making clarifications and updates to policy provisions that may contribute to stigma associated with mental health care, DOD does not have assurance that such policies are in alignment with its goals for stigma reduction and for diversity and inclusion, and efforts to encourage help-seeking may be hampered.

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[51] GAO-14-704G.

[52] Department of Defense, *Diversity and Inclusion Strategic Plan* 2012-2017 (2012).

GAO-16-404 Mental Health Care Stigma

DOD Has Not Reissued Consolidated Guidance on Denial or Suspension of Access to Classified Information or Removal from Sensitive Positions Based on Mental Health Information

DOD has taken some steps to improve personnel security program guidelines to reduce mental health care stigma and encourage help seeking as a sign of strength, but has not reissued consolidated guidance on specific mental-health-care-related issues that would support the denial or suspension of access to classified information or the removal from a position with sensitive duties. DOD is limited in its ability to change aspects of the security clearance application process, including the content of the application form and the adjudication guidelines for granting or revoking clearance eligibility because the Director of National Intelligence and the Office of Personnel Management are responsible for these aspects, which apply government-wide.[53] However, DOD has issued policies on other aspects of personnel security and advocated for changes to the clearance application form. Since 2008 DOD has issued a series of memoranda[54] clarifying for the military services and other DOD components that certain types of counseling should not be disclosed by applicants in their response to the security clearance application question on mental health,[55] and explaining what adjudicative personnel consider

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[53] Executive Order 13467 designates the Director of the Office of Personnel Management as the Suitability Executive Agent, responsible for developing and implementing uniform and consistent policies and procedures to ensure the effective, efficient, and timely completion of investigations and adjudications relating to determinations of suitability for government employment. Similarly, the Director of National Intelligence is designated as the Security Executive Agent responsible for directing oversight of investigations and determinations of eligibility for access to classified information or to hold a sensitive position. Executive Order No. 13467, *Reforming Processes Related to Suitability for Government Employment, Fitness for Contractor Employees, and Eligibility for Access to Classified National Security Information*, 73 Fed. Reg. 38103 (June 30, 2008).

[54] Department of Defense, Secretary of Defense Memorandum, *Policy Implementation – Mental Health Question, Standard Form (SF) 86, Questionnaire for National Security Positions* (Apr. 18, 2008); Department of Defense, Under Secretary of Defense for Intelligence and Under Secretary of Defense for Personnel and Readiness Memorandum, *Mental Health Counseling and Treatment and Security Clearances* (Nov. 20, 2009); Department of Defense, Secretary of Defense Memorandum, *Department of Defense Guidance on Question 21, Standard Form 86, Questionnaire for National Security Positions* (Sept. 4, 2012).

[55] Standard Form (SF) 86 is the Questionnaire for National Security Positions. Question 21 of SF 86 asks whether the applicant has consulted with a health care professional regarding an emotional or mental health condition or was hospitalized for such a condition within 7 years prior to completing the form. The form instructs applicants to answer "no" if the counseling was for not court-ordered, and was strictly marital-, family-, or grief-related and not related to violence by the applicant, or strictly related to adjustments from service in a military combat environment.

in reviewing any reported mental health information.[56] In a 2012 memorandum to all of DOD, the Secretary of Defense also clarified that a security clearance applicant's decision to seek mental health care should not, in and of itself, adversely impact that individual's ability to obtain or maintain a national security position.[57] The policy further directs that mental health counseling alone cannot form the basis of a denial of a security clearance. In fact, the memorandum notes that seeking personal wellness and recovery may favorably impact a person's eligibility for a national security position. DOD has also worked with the Office of the Director of National Intelligence to reform that question and limit the psychological health information requested, in part to avoid stigmatizing mental health.

Over the past year DCOE, the Defense Suicide Prevention Office, and the Military OneSource program have had initiatives in place to reassure servicemembers and civilian personnel that mental health care alone is unlikely to jeopardize their eligibility for a clearance.[58] According to officials from the Office of the Under Secretary of Defense for Intelligence, adjudicators seldom deny or permanently revoke clearance eligibility based solely on mental health information. Notwithstanding these steps and the aforementioned policy updates to address mental health care stigma in the personnel security program, in 19 of our 23 active duty servicemember focus groups and in all 3 of our focus groups with civilians who had returned from deployment or were training to deploy, participants commented that concern about losing their security clearance or access

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[56] Department of Defense, Under Secretary of Defense (Intelligence) Memorandum, *Implementation of Adjudicative Guidelines for Determining Eligibility for Access to Classified Information* (Aug. 30, 2006).

[57] Department of Defense Memorandum, *Department of Defense Guidance on Question 21, Standard Form 86, Questionnaire for National Security Positions* (Sept. 4, 2012). The memorandum's guidance was formalized in Department of Defense Instruction 5200.02, *DOD Personnel Security Program*, § 3(d) (Sept.9, 2014), which states that "no negative inference may be raised solely on the basis of mental health counseling. [It] by itself, shall not jeopardize the rendering of eligibility determinations or temporary eligibility for access to national security information."

[58] Military OneSource is a DOD-funded program available to all servicemembers (including those in the National Guard and reserve component), their families, and members of DOD's Civilian Expeditionary Workforce. The program provides confidential, short-term, non-medical counseling services both face-to-face and remotely, and information and resources on deployments, parenting, and relationships, among other things.

to information is a reason that people may be reluctant to seek mental health care. In many of our interviews with officials from OSD-level organizations and the military services, including those at the four selected active duty installations we visited, those officials acknowledged that concern is widespread among servicemembers that seeking mental health care will result in losing their clearance. Some of these officials themselves conceded that they would be concerned about the status of their security clearance if they sought mental health care and it became known to those serving under them or to their leadership.

Two security officials we spoke with told us that knowledge that a person had been receiving mental health care, received a diagnosis, or begun taking a related medication would prompt their command to temporarily suspend that person's access to classified information. OSD officials we spoke with who are responsible for the personnel security program told us that such an approach is not consistent with DOD's existing guidance and the intent to destigmatize mental health care. For instance, the Under Secretary of Defense for Intelligence issued a memorandum in 2006 to update and replace department guidance clarifying how mental health information should be considered in decisions about security clearance eligibility and access, including suspensions of access to classified information and removal from sensitive positions.[59] However, we found that this 2006 memorandum is not readily available and has not yet been incorporated into an administrative reissuance of DOD's manual on the personnel security program, which was last updated February 23, 1996.[60] OSD officials responsible for the personnel security program told us that they believe there could be confusion at the local level among commanders and civilian supervisors about DOD's updates to guidance about how to consider mental health information when deciding on whether to suspend access to classified information or to remove someone from a sensitive position. Officials further explained that commanders and civilian supervisors are also expected to document such decisions and their reasons and then defer to the expertise of

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[59] Department of Defense, Under Secretary of Defense (Intelligence) Memorandum, *Implementation of Adjudicative Guidelines for Determining Eligibility for Access to Classified Information* (Aug. 30, 2006).

[60] Department of Defense Regulation 5200.2-R, *Personnel Security Program* (Jan. 1, 1987) (administrative reissuance incorporating changes through Feb. 23, 1996*)*. This 2006 memorandum replaces the present guidelines published in Enclosure 2 to DOD Directive 5220.6 (Jan. 2, 1992) and Appendix 8 to DOD 5200.2-R (Jan. 1, 1987).

personnel from DOD's consolidated adjudications facility for a final decision about a person's future eligibility for accessing classified information or holding a sensitive positon. They stated that this expectation should help ensure that department policies are being carried out correctly. However, officials also acknowledged that they cannot guarantee that leaders always document such decisions, and DOD does not have data to determine how often local-level suspensions occur or for what reasons they occur.

Federal internal control standards call for agencies to develop control activities to ensure management's directives are carried out.[61] However, without reissuing consolidated guidance, incorporating subsequent revisions on denial or suspension of access to classified information or removal from assignment to sensitive duties, DOD does not have reasonable assurance that such decisions by commanders and civilian supervisors are made consistently and in accordance with existing policy and goals.

DOD Is Not Well Positioned to Measure the Progress of Its Efforts to Reduce Mental Health Care Stigma

DOD is not well positioned to measure the progress of its efforts to reduce mental health care stigma for several reasons. First, DOD has not developed a clear and consistent definition of mental health care stigma along with related goals and performance measures linked to those goals. Second, DOD's survey information on the prevalence of mental health care stigma is inconsistent across instruments and cannot be used to measure the progress of stigma reduction efforts over time. Finally, multiple entities are involved in DOD's stigma reduction initiatives, but none is charged with coordination of efforts and some information sharing is hampered.

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[61] GAO-14-704G.

DOD Has Not Developed a Clear, Consistent Definition of Mental Health Care Stigma, Goals for Reducing Stigma, or Performance Measures Linked to Those Goals

DOD Does Not Have a Clear and Consistent Definition of Mental Health Care Stigma

Our review found that DOD has not developed a clear and consistent definition for the concept of mental health care stigma, to include explanations of its contributing causes or risk factors and manners in which stigma is evident through behaviors and policies. Although DOD generally understands stigma as comprising one or more barriers to mental health care, based on our comparison of DOD and service reports, surveys and studies, and policies, we found that they apply variations on the concept of stigma in terms of a definition, proxy measures, and the manners in which stigma is manifested within the department. In its 2014 report, the RAND Corporation cited the importance of a clear and consistent definition of stigma.[62] DOD and service reports have defined the concept of stigma in different terms. For example, reports by the DOD Task Force on Mental Health[63] and the DOD Task Force on the Prevention of Suicide by Members of the Armed Forces[64] in 2007 and 2010, respectively, defined stigma as the shame or disgrace attached to something regarded as socially unacceptable. However, the two reports described different manifestations of stigma. While the 2007 report discusses public stigma, self-stigma, and structural stigma, the 2010 report outlines the manifestations differently as stereotypes, prejudice, and discrimination. Further, an Army report from 2010 defined stigma differently from the DOD reports as a perception among leaders and soldiers that help-seeking behavior will either be

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[62] The RAND Corporation, *Mental Health Stigma in the Military* (2014).

[63] Department of Defense, *An Achievable Vision: Report of the Department of Defense Task Force on Mental Health* (June 2007).

[64] Department of Defense, *The Challenge and the Promise: Strengthening the Force, Preventing Suicide and Saving Lives: Final Report of the Department of Defense Task Force on the Prevention of Suicide by Members of the Armed Forces* (August 2010).

detrimental to their career or that it will reduce their social status among their peers.[65]

As discussed in more detail in the following section, questions that DOD and the services have posed on surveys to gauge stigma utilize proxy terms to assess stigma-related barriers to mental health care, and these proxies have varied across surveys and across different survey iterations over time. For example, questions related to perceptions about the effect of mental health care on a servicemember's career and those that gauge concern about what peers and leaders will think of someone who seeks mental health care imply that DOD considers career impact and peer and leadership perceptions as part of the definition or contributing factors of stigma as barriers to mental health care. Alternately, other survey questions ask whether respondents believe that seeking help is seen as a sign of strength or weakness in the military. Stigma-related questions on the Health Related Behaviors survey have changed over time from 2005 to the present, and while these changes may have been made in an effort to improve measurement, they demonstrate inconsistency in the implied definition of stigma within a single survey instrument.

We identified 13 DOD, service, and joint staff policies that mention "stigma" with regard to mental health care. Of the selected policies we identified and reviewed, all of them reference stigma reduction as a goal or as something to be dispelled or countered. However, we found that none of them applies a clear and consistent definition of what is meant by the term "stigma," including explanations of contributing causes or risk factors and ways that stigma is evident through behavior or policies that form barriers to care—elements that could make the concept of stigma clearer and more readily measurable. All but two policies employ "stigma" as a standalone term with little specificity as to its causes, or as to how stigma can be manifested and observed in behaviors or in policies. One of the two policies that does elaborate on the term "stigma" contains a clear definition. Department of the Army Pamphlet 600-24, *Health Promotion, Risk Reduction, and Suicide Prevention* (Apr.14, 2015), defines stigma as culture that shames soldiers into believing it is not safe to seek help, and contains a lengthy discussion of stigma as a barrier to care that includes potential causes and effects of stigma and solutions to

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[65] Department of the Army, *Health Promotion, Risk Reduction, and Suicide Prevention Report* (2010).

the problem.[66] The other policy that elaborates on stigma—Army Regulation 600-63, *Army Health Promotion* (Apr.14, 2015)—does not contain a clear definition but mentions a number of solutions, such as commanders instructing personnel that a positive decision to seek mental health care should not in and of itself affect the ability to gain or maintain a security clearance.

Federal internal controls standards state that an agency's management should define objectives clearly to enable the identification of risk and define risk tolerances to include defining objectives in specific and measurable terms to allow for the assessment of performance toward achieving objectives.[67] By applying this standard to DOD, factors that contribute to stigma could be identified as risks to the objective of stigma reduction, and agreement on the ways stigma is evident in specific and consistent terms as barriers to care could allow for more ready assessments of performance, for example through behaviors or policies. Two DOD senior officials tasked with stigma reduction responsibilities acknowledged to us that stigma is a difficult term to understand, and the department's lack of clarity on what the term means is problematic. Without clarity and consistency in the definition of those barriers to care that the department generally understands as mental health care stigma, including the causes or contributing risk factors and ways that stigma is evident through behaviors and policies, there may be stakeholders across the department who do not fully understand the concept of stigma in order to recognize and take steps to reduce it. Further, without such a definition, the department may not be able to develop specific and related goals and measures with which to evaluate its progress toward reducing stigma.

DOD Has Not Developed Related Goals and Performance Measures for Stigma Reduction

DOD and service leaders have stated and policies and reports have established that stigma reduction is a stand-alone goal and also a means toward another goal of increasing access to care and reducing barriers. However, we found that DOD has not defined these goals with any specificity in measurable forms. For example, DOD does not have a stated goal for what prevalence of stigma it aims to achieve through its efforts to reduce stigma-related barriers to mental health care and

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[66] Department of the Army Pamphlet 600-24, *Health Promotion, Risk Reduction, and Suicide Prevention* (Apr. 14, 2015).

[67] GAO-14-704G.

increase access to care and related rates of utilization of services. DOD has not identified goals for influencing specific types of stigma, including self-stigma, social stigma, and structural stigma. As stated above, federal internal control standards state that agencies should allow for the assessment of performance toward achieving objectives.[68] Further, the Government Performance Results and Modernization Act states that agencies should establish performance goals in an objective, quantifiable and measurable form, and that they should be defined with sufficient precision to permit the ready assessment of progress in meeting that goal.[69]

Our review found, however, that the DOD does not have performance measures that link to its goals for reducing stigma and for efforts to reduce stigma-related barriers to mental health care, which would help routinely evaluate the effectiveness of its approach. According to DCOE officials, they recently secured funding to conduct a one-time study of the effect of its stigma-reduction campaign, Real Warriors, and stigma-reduction campaigns of the departments of Veteran's Affairs and Health and Human Services, on servicemembers' and veterans' mental health perceptions and their knowledge of resources. OSD officials explained to us that until they have specific measures in place to track trends over time, they will use mental health care utilization rates to measure the effectiveness of stigma reduction efforts. Officials cite increasing mental health utilization rates as evidence of the effectiveness of its collective stigma reduction efforts, but acknowledged that they do not yet have other measures in place to consistently gauge the specific effect of stigma reduction efforts over time or across the department. While officials stated that increased utilization rates is one important measure, DOD does not know the extent to which increasing utilization rates for mental health care are attributable to reduced levels of stigma or to other factors. Additional variables can also influence the utilization of mental health care, including changes in the prevalence of logistical barriers to care. For example, a study of Army National Guard soldiers at three different time periods found that logistical barriers (e.g., uncertainty about where to get help, inadequate transport, difficulty scheduling an appointment, inability to get time off work, expensive care, lack of providers available, lack of

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[68] GAO-14-704G.

[69] Pub. L. No. 111-352 (Jan.4, 2011).

proximity to care) were reported nearly as often (by 31 percent of respondents) as stigma (34 percent).[70]

As DOD develops a more coordinated effort to combat mental health care stigma, without having clear, measureable goals linked to reducing stigma-related barriers to mental health care and performance measures to determine whether the goals are being met, DOD will not have reasonable assurance that its efforts are effective and appropriately targeted toward achieving of these desired outcomes.

Information on Mental Health Care Stigma from DOD's Existing Surveys is Inconsistent and Cannot be Used to Measure the Progress of Stigma Reduction Efforts

Our review of DOD- and service- sponsored surveys found that multiple surveys contain questions relevant to mental health care stigma, but inconsistencies in the surveys preclude efforts to measure progress over time. The surveys identified are administered by different entities, encompass varying populations, and measure mental health care stigma with different questions and for different purposes. Among department-wide surveys, the Health Related Behaviors Survey targets the active and reserve components, while the DEOC Survey is conducted at the command level and can include active duty, reserve component, or DOD civilian members. Among service-sponsored surveys, the Air Force Community Assessment Survey population includes active duty Air Force, Air Force Reserve, and Air National Guard members, their spouses, and civilian employees of the Air Force components. The Army MHAT studies, on the other hand, had much smaller target populations of maneuver unit platoons of soldiers or soldiers and marines deployed in combat theater in Afghanistan or Iraq.

Our review also found that DOD- and service-sponsored surveys utilize different proxy measures for stigma rather than asking respondents specifically whether they believe stigma exists in the military. Specifically, each of the six surveys we reviewed utilizes a form of proxy question that ask respondents about their perceptions of the effect of mental health care on their career, whether seeking mental healthcare would be seen as weak, or both, among other things. These questions are worded differently on each survey. For example, the 2011 Health Related Behaviors Survey of active component servicemembers asks

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[70] Marcia Valenstein et al., "Reported Barriers to Mental Health Care in Three Samples of U.S. Army National Guard Soldiers at Three Time Points," *Journal of Traumatic Stress,* Vol. 27, No. 4 (2014).

respondents their opinion about the effects of counseling, therapy, or treatment on their career. The DEOC survey asks about perceptions of the effects of treatment for depression, suicidal thoughts, or post-traumatic stress disorder in particular on career. The Air Force Community Assessment Survey asks about the effects of counseling from specific types of providers, such as chaplains or psychologists, on a person's career. Additionally, some surveys also measure concerns such as being seen as weak and concerns about what peers and leaders will think of a member who seeks mental health care. Appendix IV provides additional information about the six types of survey instruments we reviewed and the different questions they contain relevant to mental health care stigma. DOD officials explained to us that the diversity of questions about stigma is attributable to the fact that most surveys are developed independently in accordance with the services' requirements, although surveys that include personnel in more than one of the military services are reviewed and approved by the Defense Manpower Data Center.[71]

In addition to variations across survey instruments, the methodology and administration of some of the surveys we reviewed vary from iteration to iteration, which preclude the department's ability to use these data sources to gauge the effectiveness of stigma reduction efforts over time. We reviewed multiple iterations of the Health Related Behaviors Survey dating back to 2005 and including both active duty and reserve component versions of the survey. Although we deemed each of the surveys sufficiently reliable for producing estimates at snap shots in time, we identified differences in the survey methodologies, administration, populations and questions across years, which precluded our comparing the surveys across years or conducting trend analyses over time. Agency officials also acknowledged that changes in survey administration and methodology, such as the change in the administration of the Health Related Behaviors Survey of reserve component servicemembers from an in-person approach in 2010-2011 to a web-based approach in 2014, limited the comparisons of data over time. Similarly, DOD officials told us that changes to the sampling methodology of the MHAT studies in 2009,

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[71] In addition to the Defense Manpower Data Center coordination of surveys that cross services, the Inter-Service Survey Coordinating Committee coordinates surveys among the Defense Manpower Data Center, the military services and the Defense Health Agency. Inter-Service Survey Coordinating Committee representatives brief survey topics and planned dates to fellow members at least semi-annually.

while made to increase the scientific rigor and usefulness of the studies for trend analysis, mean that the ability to conduct trend analysis prior to 2009 is limited.

Federal standards for statistical surveys require the use of consistent data collection procedures in order to maintain a consistent data series over time.[72] However, continuous improvement efforts sometimes result in a trade-off between the desire for consistency and a need to improve a data collection, such as the 2009 change in sampling methodology for the MHAT studies which then enabled the Army to make comparisons over time between the sample populations of soldiers and marines. In such situations where changes are needed in key variables or survey procedures for a data series, federal standards require the development of adjustment methods to preserve trend analyses.[73]

DOD makes some effort to use the information collected in surveys to gauge perceptions related to seeking mental health care. Officials from the Office of the ASD (HA) told us that the Interagency Task Force on Mental Health uses results of the Health Related Behaviors and Status of Forces surveys to monitor risks and keep department leadership apprised with respect to mental health care perceptions. However, variations in survey administration between survey iterations prevent the department from using these data for identifying or monitoring trends over time. A study published in 2014 and conducted by researchers from the Walter Reed Army Institute of Research in partnership with others sought to analyze trends over time in data from two survey instruments collected between 2002 and 2011 and found increases in mental health utilization and decreases in stigma.[74] However, while the study observed trends over time in these measures, variations in survey methodologies and questions used to measure stigma and utilization represented limitations to the analysis. Furthermore, the study was not designed to assess the

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[72] Office of Management and Budget, *Standards and Guidelines for Statistical Surveys* (September 2006).

[73] Office of Management and Budget, *Standards and Guidelines for Statistical Surveys* (September 2006).

[74] P.J. Quartana, J.E. Wilk, J.L. Thomas, R.M. Bray, K.L.R. Olmsted, J.M. Brown, J. Williams, P.Y. Kim, K. Clarke-Walper and C.W. Hoge, "Trends in Mental Health Services Utilization and Stigma in US Soldiers from 2002 to 2011," *American Journal of Public Health*, Published online ahead of print July 17, 2014.

possible causes of these trends or to measure the effects of department efforts to decrease stigma and increase mental health utilization.

DCOE officials acknowledged to us the limitations they face in trying to track changes in the prevalence of stigma over time and relate them to the effectiveness of departmental stigma-reduction initiatives. According to these officials, DCOE has contracted with the RAND Corporation to develop a better set of survey questions that are intended to remain consistent over time for trend analysis purposes to improve upon information collected from the Health Related Behaviors Survey. However, DCOE officials explained that they are unsure when this new question set will be administered department-wide because of a lengthy departmental review and approval process and the need to identify an existing survey instrument in which to embed the new questions. Notwithstanding these preliminary steps to create a new survey, DOD has not developed a consistent method to collect and analyze survey data to help ensure that reliable data are available related to mental health care stigma. Without such an approach, DOD does not have needed information to assess the prevalence of stigma and analyze trends over time in order to determine the effectiveness of its stigma reduction efforts.

Multiple Entities Are Involved with Stigma Reduction, but None Is Charged with Coordination of Efforts and Some Information Sharing Is Hampered

Responsibilities for stigma reduction are dispersed among various organizations within and across OSD and the military services. Federal internal control standards state that the assignment of responsibility and delegation of authority are needed to achieve agency objectives.[75] With regard to DOD's mental health stigma reduction, no single entity is charged with oversight or coordination of stigma reduction efforts or efforts to reduce barriers to care.

Some DOD and service entities have direct responsibilities for reducing stigma specified in policies or in their mission statements, while others are involved in stigma as a collateral function even if not charged with such responsibilities directly. Specifically, our review found that over 20 different DOD and military service entities have responsibilities for managing aspects of mental health care stigma reduction and related efforts to improve perceptions about care, expand literacy, and promote help-seeking as a sign of strength (see table 3).

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[75] GAO-14-704G.

Table 3: DOD and Military Service Entities with Responsibilities for Addressing Mental Health Care Stigma Reduction and Related Efforts

Defense entity	Responsibility
Defense-wide office or agency	
Under Secretary of Defense for Personnel and Readiness	Establishes policy for and oversees stigma reduction related to: command notification requirements for mental health care, substance abuse, mental health evaluations, suicide prevention and counseling services, and maintenance of mental health in military operations.
Assistant Secretary of Defense for Health Affairs	Oversees compliance and develops guidance for the DOD components' combat operational stress program requirements and oversees and develops guidance for mental health treatment and mental health evaluations. Provides funding for and oversight of a Psychological Health and Resilience research portfolio that includes projects designed to address stigma associated with mental health issues and seeking care. This research portfolio is managed, and also funded by, the Army Medical Research and Materiel Command.
Director, Defense Health Agency	Promotes combat operational stress initiatives that reduce stigma associated with seeking mental health care. Manages and monitors the Directors of Psychological Health Program, which among other things designates specific roles for psychological health advocacy at the installation, military departments, and DOD levels to facilitate the coordination of clinical, counseling, and other services promoting the psychological health of servicemembers and their families; and outlines a uniform psychological health leadership structure for the reserve components that parallels the active component structure, to ensure that the psychological health needs of reserve component and National Guard servicemembers and their families are met.
Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury	Provides guidance across DOD programs related to psychological health and traumatic brain injury, including research, education, training, and outreach programs for mitigating stigma.
Office of the Assistant Secretary of Defense for Readiness / Director, Force Training[a]	Develops the pre-deployment training curriculum for DOD's Civilian Expeditionary Workforce that includes a "mind fitness" components, which educates civilians about mental health in combat environments and available resources, according to officials.
Deputy Assistant Secretary of Defense for Military Community and Family Policy[a]	Provides, through the Military OneSource program[b] and Military and Family Life Consultant[c] program, brief, non-medical counseling to active and reserve component servicemembers and DOD Civilian Expeditionary Workforce members, implementing privacy and confidentiality policies that aim to reduce stigma.
Director, Defense Suicide Prevention Program	Develops and implements strategic communications for all levels of DOD to promote suicide prevention and resilience messaging and reduce stigma.
Assistant to the Secretary of Defense for Public Affairs	Develops, coordinates, and disseminates—in support of the Director, Defense Suicide Prevention Program—messages focusing on suicide prevention, intervention, and surveillance to support stigma reduction and reduce the potential for suicide contagion.
Defense Equal Opportunity Management Institute (DEOMI)	Facilitates the DEOMI Organizational Climate Survey, which includes questions on perceptions about mental health.
Under Secretary of Defense for Intelligence	Develops, coordinates, and oversees the implementation of DOD policy, programs, and guidance for personnel security, which includes the consideration of mental health information.
The Joint Staff	Develops policies, doctrine, metrics and measures for the Chairman of the Joint Staff's Total Force Fitness framework, a program that addresses stigma elimination among other things.

Defense entity	Responsibility
Department of the Army	
Assistant Secretary of the Army for Manpower and Reserve Affairs / Deputy Chief of Staff, G-1	Establishes and oversees policies and training requirements for the Comprehensive Soldier and Family Fitness program for soldiers and civilians, which among other things, affects stigma reduction.
Office of the Surgeon General and Commanding General, U.S. Army Medical Command	Provides guidance on behavioral health and advises the Deputy Chief of Staff, G-1, on psychiatric aspects of resilience and performance enhancement training for the Comprehensive Soldier and Family Fitness program. Ensures that Walter Reed Army Institute of Research supports Comprehensive Soldier and Family Fitness through training development and evaluation.
U.S. Army Medical Research and Materiel Command	Provides funding for and management of a Psychological Health and Resilience research portfolio that includes projects designed to address stigma associated with mental health issues and seeking care.
U.S. Army Medical Department / Army Public Health Center/ Behavioral and Social Outcomes Program	Oversees the Behavioral and Social Outcomes Program, which conducts behavioral health field studies and epidemiological consultations to specific installations upon request to identify and assesses psychological and social threats to soldiers' health and combat readiness—including stigma—and recommends ways the Army can prevent or reduce these negative behavioral and social health outcomes.
Department of the Navy	
Deputy Chief of Naval Operations for Manpower, Personnel, Training and Education, N1	Establishes policy and training for and oversees the Suicide Prevention Program and Operational Stress Control Program, both of which address stigma for mental health care.
Bureau of Medicine and Surgery	Provides guidance to the Navy Medicine Enterprise on psychological health issues, including stigma. Oversees the Naval Combat Operational Stress Control Center, which among other things works to reduce stigma through research and education. Oversees the Psychological Health Outreach Program for the Navy Reserve and Marine Corps Reserve, which provides licensed clinical mental health care screenings and makes referrals to providers to, among other things, help overcome mitigate stigma through confidentiality.
Department of the Air Force	
Office of the Deputy Chief of Staff for Manpower, Personnel and Services, A1	Oversees and establishes policy for activities related to an Air Force-wide resiliency and fitness approach called Comprehensive Airman Fitness that emphasizes early mental health care and stigma reduction. Establishes policy and training requirements for and oversees the Air Force Suicide Prevention Program.
The Surgeon General	Develops and oversees Comprehensive Airman Fitness training related to psychological health and mental fitness.
Air Force Medical Operations Agency	Administers the Air Force Community Assessment Survey, which gathers information about perspectives on mental health care.
Marine Corps	
Deputy Commandant for Manpower and Reserve Affairs	Establishes the Headquarters Marine Corps Combat and Operational Stress Control Program and oversees quality assurance and disseminates information and best practices to among other things, help reduce stigma. Establishes a Marine Corps Suicide Prevention Program.
Director, Marine and Family Programs Division	Oversees and establishes guidance, plans, policy, and training requirements for the Marine Corps Suicide Prevention Program.

Defense entity	Responsibility
National Guard	
National Guard Bureau, Director of Behavioral Health and Wellness	Leads the National Guard Psychological Health Program to among other things, reduce stigma associated with seeking assistance for mental health and substance abuse issues and decrease barriers to treatment by facilitating access to resources.

[a]The Offices of the Assistant Secretary of Defense for Readiness and the Deputy Assistant Secretary of Defense for Military Community and Family Policy are the only entities we identified as having a stigma-related effort directly targeting deployed DOD civilian personnel.

[b]Military OneSource is a DOD-funded program available to all servicemembers (including the National Guard and reserve component), their families, and members of DOD's Civilian Expeditionary Workforce. The program provides confidential, short-term, non-medical counseling services both face-to-face and remotely, and information and resources on deployments, parenting, and relationships, among other things.

[c]Military and Family Life Consultants provide worldwide, nonmedical counseling to any servicemember, their family, and members of DOD's Civilian Expeditionary Workforce for circumstances needing brief intervention.

Most of these entities focus their efforts on the active and reserve components, and only two of them have stigma reduction-related efforts in place aimed directly at the deployed civilian population. The Deputy Under Secretary of Defense for Readiness develops a pre-deployment training curriculum for DOD civilians that emphasizes psychological fitness and discusses some available resources. The Deputy Assistant Secretary of Defense for Military Community and Family Policy provides two nonmedical counseling programs that include members of DOD's Civilian Expeditionary Workforce.

Our review found that some information sharing has been hampered between OSD and service entities with stigma-related responsibilities and no single entity is coordinating or overseeing these related efforts. We observed some instances in which organizations were unaware of initiatives or the research of other offices. For example:

- Officials we spoke with from DOD offices that have responsibilities for stigma reduction were not familiar with some stigma-related research and program initiatives ongoing or completed by other offices.

- A September 2014 memorandum by the Under Secretary of Defense for Personnel and Readiness noted that DOD is trying to minimize its use of the term "stigma" when discussing the promotion of help-

seeking behaviors.[76] However, some OSD officials we spoke with were unsure about the impetus for this change and whether it is still endorsed despite numerous policies and programs that utilize the word "stigma."

In addition to challenges with information sharing, we also identified an apparent gap in policy and some overlap in research and anti-stigma campaigns. For example, civilian personnel are not included in most of the policies we reviewed, and DOD's goals for stigma reduction for deployed civilians in particular are unclear. On the other hand, as discussed previously, a number of DOD offices are working separately on initiatives to better understand stigma and track its prevalence in the DOD-wide population.

Based on our interviews with OSD officials, no consensus exists about which office, if any, should have the responsibility for coordination and oversight of stigma reduction initiatives. Moreover, according to OSD officials, DOD does not have a coordinating authority in place for carrying out and overseeing the department's broader efforts toward reducing barriers to mental health care in general. Insofar as DOD's goal for stigma reduction is also a means to mitigate barriers to help-seeking behaviors and to facilitate access to care, then without a coordinating entity, DOD does not have reasonable assurance that it is efficiently allocating resources toward stigma reduction as opposed to other efforts to reduce barriers, while also avoiding gaps in its efforts and unnecessary duplication among entities. DOD may also be missing opportunities for ensuring consistent and uniform messaging and outreach, and for optimizing leverage of resources and expertise in addressing mental health care stigma. Similarly, no single entity within DOD is coordinating the collection and use of survey information on mental health care stigma, discussed previously, in order to monitor the prevalence of stigma and measure stigma reduction efforts across the department.

Conclusions

The steps DOD has taken to improve perceptions about mental health among servicemembers, and to a smaller extent deployed civilians, demonstrate the department's commitment to an approach it characterizes as a cultural change marked by expectations that mental

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[76] Department of Defense, Under Secretary of Defense (Intelligence) Memorandum, *Personnel Security Clearance Awareness Campaign* (Sept. 15, 2014).

health care is a normal and routine part of overall health care and wellness. However, certain limitations in DOD's approach may impede progress toward this goal. Unless DOD begins collecting and monitoring perceptions of its deployed civilian personnel regarding mental health care or other issues that affect morale and well-being, DOD may be challenged to meet its goals for retaining top civilian employees and recruiting individuals for future deployment. The existence of unclear and inconsistent policies that may influence negative perceptions surrounding mental health care among servicemembers and deployed civilians, including those who need access to classified information or seek positions with sensitive duties, may also hamper the department's achievement of its policy goal of reducing stigma and encouraging help-seeking among servicemembers. Similarly, until DOD reissues consolidated guidance on the personnel security program, the potential for inconsistent decision making by commanders and leaders in suspending clearances or removing individuals from sensitive positions may further impede the department's efforts to address stigma. While DOD and the services study mental health care stigma and collect data on certain aspects of servicemembers' perspectives about mental health care, the fact that the department does not have a consistent method to collect and analyze survey data related to stigma prevents the department from using such information to track progress over time. Together, the absence of a clear and consistent definition of those barriers to care that DOD generally understands as "mental health care stigma," related goals and measures for reduction of stigma-related barriers to care, and a coordinating authority with oversight prevent the department from positioning itself to evaluate progress and demonstrate efficacy and results from its initiatives. As a result, DOD is limited in its ability to ensure resources are efficiently allocated toward stigma reduction as opposed to other efforts to reduce barriers, while also avoiding gaps in its efforts and unnecessary duplication among entities.

Recommendations for Executive Action

We recommend that the Secretary of Defense direct the Under Secretary of Defense for Personnel and Readiness to take the following six actions:

- collect and monitor deployed civilians' perceptions related to mental health care.

- leverage recommendations made by the RAND Corporation in its 2014 report on mental health stigma in the military to update and clarify policies as needed to remove stigmatizing provisions, such as

career restrictions that may be too limiting for individuals who have received mental health care.

- establish a clear, consistent definition of those barriers to care generally understood by DOD as "mental health care stigma," to include explanations of its causes or contributing risk factors and ways that stigma is apparent in behaviors and policies.

- establish goals for efforts to address barriers to care generally understood by DOD as "stigma reduction efforts," and performance measures that link to these goals.

- develop a method to collect and analyze information on barriers to seeking mental health care, including stigma, so that reliable data may be gathered and used to measure the effectiveness of stigma reduction efforts over time.

- designate an entity to coordinate efforts to reduce mental health care stigma, among other barriers to care.

We recommend that the Secretary of Defense direct the Under Secretary of Defense for Intelligence to take the following action:

- reissue consolidated guidance, incorporating subsequent updates for the denial or suspension of access to classified information and for assignment to sensitive duties based solely on information about mental health care.

Agency Comments and Our Evaluation

We provided DOD a draft of this report to review and comment. In reviewing our draft report, DOD expressed concerns over the wording of two of our recommendations. In discussions with DOD about those concerns, we agreed to clarify the recommendations in question slightly. Specifically, we added a short phrase that more accurately reflects DOD's scope of concern regarding its stigma reduction efforts. In its final comments, DOD concurred or concurred with comment on each of our seven recommendations and provided some general overall remarks. DOD's comments are reprinted in appendix V. DOD also provided technical comments which we incorporated, as appropriate.

In its general comments regarding our report, DOD stated that our report would have been strengthened if we had also described the stigma perceived by servicemembers related to seeking care for physical health

conditions that are incompatible with military service, as well as the stigma experienced by civilians in highly sensitive, high risk occupations. While we recognize the potential benefits of doing this, the National Defense Authorization Act for Fiscal Year 2015 required us to assess the perception of the impact of the stigma of mental health treatment for members of the armed forces and deployed civilian employees and to assess the policies, procedures, and programs to reduce such stigma. Therefore, comparisons of mental health stigma in the military with different types of stigma or with stigma in non-military populations would have been outside the scope of our review. Moreover, the RAND Corporation reported in 2014 that while stigma is a concern both inside and outside the military, comparing data on the prevalence of stigma in the general U.S. population to prevalence within the military poses challenges because of differences in the way stigma is measured between the two groups.[77] As a result, the RAND Corporation did not draw such comparisons.

DOD also stated in its general comments that it has used the concept of resilience to explore various interventions to strengthen the ability of its servicemembers to weather the many stresses of military life. As such, DOD's efforts are directed at various utilization efforts such as ensuring adequate treatment capacity, increasing access to primary care and Embedded Behavioral Health, and ensuring that servicemembers get the intensity and duration of care needed to achieve meaningful, measurable outcomes. We discuss in our report that DOD has taken steps to reduce stigma as a barrier to seeking mental health care and that DOD's methods of approach for reducing stigma by making mental health care more accessible, private, and routine is through implementation of clinical and non-clinical treatment initiatives such as embedding mental health providers within some units of each active component; integrating mental health care in primary care settings of military treatment facilities; and ensuring the widespread availability of nonmedical counseling to provide alternative methods of assistance outside the clinical environment. We also discuss that other barriers to seeking care exist and include availability of services, knowledge about where to get help, the ease of scheduling an appointment, and having the time off from work to seek care. We note in our report that a study of Army National Guard soldiers at three different time periods found that logistical barriers (e.g.,

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[77]The RAND Corporation, *Mental Health Stigma in the Military* (2014).

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uncertainty about where to get help, inadequate transport, difficulty scheduling an appointment, inability to get time off work, expensive care, lack of providers available, lack of proximity to care) were reported nearly as often (by 31 percent of respondents) as stigma (34 percent).[78] DOD in its general comments further cited emerging research that indicates stigma itself is not necessarily of critical importance to the decision people make about whether or not to seek care. The many factors that affect a person's decision to seek care or not underscore the need for DOD to determine how stigma affects mental health care utilization, if at all. This is important given that utilization is DOD's current measure for its stigma reduction efforts and that programs have been designed to help achieve that goal.

Further in its general comments, DOD stated that work is underway toward achieving the goal of having at least one DOD-wide survey that incorporates a consistent series of questions that will permit DOD to track and trend attitudes about stigma over time. We believe this is a positive step as consistent data collection procedures are needed to maintain a consistent data series over time. We acknowledged DOD's effort to use the information collected in surveys to gauge perceptions related to seeking mental health care, as well as that the RAND Corporation is in the process of developing a new set of survey questions that are intended to remain consistent over time for trend analysis to improve upon information collected from the Health Related Behaviors Survey. We believe that this is a step in the right direction to more accurately gauge the prevalence of stigma over time. However, in our report, we also stated that DOD officials explained that they were not sure when this new question set may be administered department-wide and they had not identified an existing survey instrument in which to embed the new questions. Until the consistent series of survey questions is fully developed and broadly administered, DOD may not fully know the extent to which stigma and its causes are negatively impacting the help-seeking behaviors that the department is working to encourage.

DOD concurred on our first recommendation that it collect and monitor deployed civilians' perceptions related to mental health care. However, DOD stated that it recognizes that more can be discovered about

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[78] Marcia Valenstein et al., "Reported Barriers to Mental Health Care in Three Samples of U.S. Army National Guard Soldiers at Three Time Points," *Journal of Traumatic Stress*, Vol. 27, No. 4 (2014).

deployed federal civilians' perceptions of mental health treatment and subsequent impacts of these perceptions on their mental health care utilization and readiness. DOD also stated a means now exists for tracking which civilians are deployed, and work is underway to automate this information vice relying on data calls to the services. However, based on our review, DOD's database application used to identify deployed civilians has had significant data quality issues, and as a result, according to DOD officials we spoke with, the last information to be produced from it was in January 2015 with an estimate of June 2016 as the earliest possible date they would be able to report information on deployed civilians again. Additionally, DOD stated in its response that it cannot require its deployed federal civilian employees to seek care or participate in DOD surveys specific to their perceptions related to mental health care while deployed. We recognize this point, but continue to believe that because DOD relies on deployed civilians to perform a variety of important duties to support operations both overseas alongside servicemembers as well in response to homeland emergencies and humanitarian missions, more efforts are needed to more accurately and completely identify and monitor the needs—both mental as well as physical—of its deployed civilians. This effort would allow DOD to more fully assess the organizational climate of its total workforce as well as create a more supportive environment for that workforce.

DOD concurred with our second recommendation that it leverage recommendations made by the RAND Corporation in its 2014 report on mental health stigma in the military to update and clarify policies as needed to remove stigmatizing provisions, such as career restrictions that may be too limiting for individuals who have received mental health care.

DOD concurred with our third recommendation that it establish a clear, consistent definition of those barriers to care generally understood by DOD as mental health care stigma, to include such explanations of causes or contributing risk factors and ways that stigma is apparent in behaviors and policies. DOD stated that it agrees that focusing on stigma-associated barriers to seeking care is the most fruitful way in improving its ability to target its efforts and measure the impact of those efforts.

DOD concurred with our fourth recommendation that DOD establish goals for efforts to address barriers to mental health care generally understood as stigma reduction efforts and performance measures that link to these goals. DOD stated that while the relationship between an individual's perception of stigma and health seeking behavior is a complex one, it intends to continue to identify perceptions and to measure

its level of success in increasing servicemembers' willingness to seek and continue care.
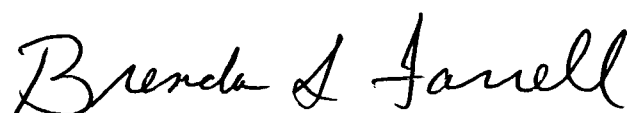
DOD concurred with our fifth recommendation that it develop a method to collect and analyze information on barriers to seeking mental health care, including stigma, so that reliable data may be gathered and used to measure the effectiveness of stigma reduction efforts over time.

DOD concurred with our sixth recommendation that it designate an entity to coordinate efforts to reduce mental health care stigma, among other barriers to care. However, DOD stated that it agrees that designating an existing work group with members from different sections of the department to take on this responsibility would allow for a collaborative, cross-agency approach to this issue. While having an existing work group take on the responsibility of coordinating efforts to reduce mental health care could address our recommendation, it will be important that the existing work group provide sufficient oversight and coordination of the various efforts undertaken to reduce barriers to seeking care. Further, we believe that the entity be vested with the necessary authority and resources to help set priorities and to make timely decisions and actions for success.

DOD concurred with our seventh recommendation that DOD reissue consolidated guidance, incorporating subsequent updates for the denial or suspension of access to classified information and for assignment to sensitive duties based solely on information about mental health care. However, DOD stated that it has new guidance that is in the coordination process and should be completed within a year. DOD did not identify what the new guidance will specifically cover. To sufficiently address our recommendation, we believe the new personnel security program guidance should incorporate subsequent updates to DOD's existing manual on the personnel security program in order to clarify for commanders and civilian supervisors how to consider mental health information when deciding on whether to suspend access to classified information or to remove someone from a sensitive position.

We are sending copies of this report to appropriate congressional committees; the Secretary of Defense; the Secretaries of the Army, the Navy, and the Air Force; the Commandant of the Marine Corps, the Under Secretary of Defense for Personnel and Readiness; and the Under Secretary of Defense for Intelligence. In addition, the report will be available at no charge on the GAO website at http://www.gao.gov.

If your or your staff have any questions about this report, please contact me at (202) 512-3604 or farrellb@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made key contributions to this report are listed in appendix VI.

Brenda S. Farrell
Director, Defense Capabilities and Management

Appendix I: Scope and Methodology

To obtain measures of military servicemembers' and deployed civilians' reported perceptions about mental health care stigma in the military, we identified Department of Defense (DOD)-wide and service-sponsored administered surveys that contained specific questions related to barriers to seeking mental health care, including perceptions of stigma.[1] The surveys that we identified and reviewed for stigma-related questions were:

1. The 2011 Health Related Behaviors Survey of Active Duty Military Personnel;

2. The 2010-2011 Health Related Behaviors Reserve Component Survey;

3. The Defense Equal Opportunity Management Institute (DEOMI) Organizational Climate Surveys from 2015;

4. The 2014 Status of Forces Survey of Active Duty Members;

5. The 2013 and 2012 Mental Health Advisory Team (MHAT) Studies (MHAT-9 and Joint MHAT-8); and

6. The 2013 Air Force Community Assessment Surveys for Active Duty, Air Force Reserve, and Air National Guard.

For the 2011 active component and the 2010-2011 reserve component Health Related Behaviors Surveys, we obtained data from DOD for the survey questions related to stigma and conducted a weighted analysis for stratified categories of interest. Estimates presented in this report from our analyses of survey data have margins of error within +/- 13 percentage points. While we found methodological differences across iterations of the Health Related Behaviors surveys that do not allow for trend analyses over time, we determined that the studies were sufficiently reliable for estimating the perceptions of stigma at individual snapshots in time.

For the other four surveys,(1) the Defense Equal Opportunity Management Institute (DEOMI) Organizational Climate Survey; (2) the

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[1] For purposes of this report, the term deployed civilians refers to federal civilian employees of the Department of Defense who are organized, trained, cleared, equipped, and ready to deploy in support of combat operations by the military, contingencies; emergency operations; humanitarian missions, disaster relief; restoration of order; drug interdiction; and stability operations. Collectively, this set of DOD federal civilian employees is known as the DOD Civilian Expeditionary Workforce.

Status of Forces Survey; (3) The MHAT Studies (MHAT-9 and Joint MHAT-8); and (4) the 2013 Air Force Community Assessment Surveys for Active Duty, Air Force Reserve, and Air National Guard, we reviewed the related reports for relevancy by evaluating the questions and target populations and found that they all contained questions relevant to mental health care stigma. We also reviewed reports of the methodology and any limitations and findings of the MHAT-9 and Joint MHAT-8 and the 2013 Air Force Community Assessment surveys and found them to be sufficiently reliable sources for estimates of perceived stigma. However, while the estimates of stigma are not comparable between surveys or over time, we used these surveys to determine the perception that stigma exists in respondents at various points in time as measured by each survey. To further understand the methodology results of each of these surveys, we conducted interviews with officials within DOD and the services as needed.

To supplement our analyses of these surveys, we conducted a series of focus groups to collect perspectives on career impacts of seeking mental health care, command and leadership levels of support of those seeking care, and possible mental health resources from a non-generalizable sample of servicemembers' across all four services as well as federal civilian employees who had deployed in the past or who were presently in training to deploy. To do so, we selected four geographically dispersed installations—one for each of the four services—and conducted 23 focus groups of active duty military servicemembers, organized by rank and rate categories, at each of those four locations. Additionally, we conducted 3 focus groups, at two different locations, with DOD federal civilian employees who had deployed in the past or were training to deploy. We performed a content analysis of comments from each of the focus groups which were aggregated and verified to support our findings throughout the report. Further details of our focus group methodology and results are presented in appendix III.

In addition to the 187 servicemembers and 22 civilians that participated in our focus groups, we interviewed servicemembers, unit leaders, clinical and non-clinical providers, and other officials at the four selected installations where we conducted the servicemember focus groups. We compared information we gathered from our interviews and survey reviews with DOD's *Diversity and Inclusion Strategic Plan for 2012-2017* which states that the department should ensure a framework to oversee

and monitor organizational climate[2] and the *Standards for Internal Control in the Federal Government* which requires management to use quality information to inform decisions and evaluate performance in achieving key objectives.[3] We used these standards to assess the extent to which DOD had collected and monitored servicemembers' and deployed federal civilians' perceptions of stigma associated with seeking mental health care.

To determine the extent to which DOD has policies and related efforts to address mental health care stigma among servicemembers and deployed civilians, including for personnel who have access to classified information, we identified White House Executive guidance to improve mental health outcomes for veterans, servicemembers, and their families. [4] We also identified a cross-agency priority goal established by the Office of Management and Budget regarding the improvement of mental health outcomes for servicemembers, veterans, and their families.[5] The goal calls for the reduction of barriers to seeking mental health care and support by identifying, expanding, and promoting programs, initiatives, and efforts to reduce negative perceptions, among other things. Additionally, we identified within the *Standards for Internal Control in the Federal Government* the importance of having clear, updated policies that align with an organization's mission and goals.[6] We applied these standards to DOD's goals for stigma reduction and inclusiveness. Through literature searches and interviews with officials from each of the organizations listed in table 4, we identified DOD-level and service-level policies, memoranda, and other information to

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[2] Department of Defense, *Diversity and Inclusion Strategic Plan 2012-2017* (2012).

[3] GAO, *Standards for Internal Control in the Federal Government*, GAO-14-704G (Washington, D.C.: September 2014).

[4] Executive Order No. 13652, *Improving Access to Mental Health Services for Veterans, Service Members, and Military Families* 77 Fed. Reg.54783 (Sept. 5, 2012); Office of Management and Budget, Cross Agency Priority Goals (March 2014).

[5] Office of Management and Budget, Cross-Agency Priority Goals (March 2014). Cross-agency priority goals are outcome-oriented goals covering a limited number of crosscutting policy areas and management improvements across the Federal Government in areas of information technology, financial management, human resources, and real property. Office of Management and Budget Circular No. A-11, *Preparation, Submission, and Execution of the Budget*, pt. 6, § 220 (2015).

[6] GAO-14-704G.

determine what efforts exist, including training and education, for reducing mental health care stigma for both military and civilian personnel.

Table 4: DOD and Service Locations Visited or Contacted

DOD	• Office of the Under Secretary of Defense for Intelligence
	• Office of the Under Secretary of Defense for Intelligence
	• Office of the Assistant Secretary of Defense for Manpower and Reserve Affairs
	• Office of the Deputy Assistant Secretary of Defense for Military Community and Family Policy
	• Office of the Deputy Assistant Secretary of Defense for Military Personnel Policy
	• Office of the Deputy Assistant Secretary of Defense for Civilian Personnel Policy
	• Office of the Deputy Assistant Secretary of Defense for Readiness
	• Office of the Assistant Secretary of Defense for Health Affairs
	• Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury
	• National Guard Bureau
	• U.S. Central Command
	• Defense Suicide Prevention Office
	• Defense Office of Hearings and Appeals
	• Office of Diversity Management and Equal Opportunity
	• Defense Equal Opportunity Management Institute
	• Defense Civilian Personnel Advisory Service
	• DOD Consolidated Adjudications Facility
	• Defense Manpower Data Center
	• Uniformed Services University of the Health Sciences
	• Civilian Expeditionary Workforce/Ministry of Defense Advisors Deployment Center, Camp Atterbury, Indiana
Army	• Office of the Deputy Under Secretary of the Army
	• Office of the Assistant Secretary of the Army for Manpower and Reserve Affairs
	• Office of the Deputy Chief of Staff, G-1
	• Office of the Surgeon General/Army Medical Command
	• Center for Military Psychiatry and Neuroscience Research, Walter Reed Army Institute of Research
	• U.S. Army Training and Doctrine Command
	• U.S. Army Public Health Command
	• Office of the Chief of Army Reserve
	• Army National Guard
	• Army Physical Disability Agency
	• Fort Drum, New York
Navy	• Bureau of Medicine and Surgery
	• Navy Suicide Prevention Program
	• Commander, Navy Reserve Force Command
	• Joint Expeditionary Base Little Creek-Fort Story, Virginia

Air Force	• Office of the Deputy Chief of Staff for Manpower, Personnel and Services, A1
	• Air Force Medical Operations Agency
	• Air National Guard
	• Scott Air Force Base, Illinois
Marine Corps	• Office of the Director, Health Services, Headquarters Marine Corps
	• Office of Manpower and Reserve Affairs, Headquarters Marine Corps,
	• Office of the Chaplain of the Marine Corps
	• Camp Lejeune, North Carolina

Source: GAO | GAO-16-404

In addition to the organizations listed in table 4, we also interviewed researchers from the RAND Corporation and the Institute of Medicine of the National Academies to discuss their evaluations of various aspects of DOD mental health programs, policies, and other efforts, to include DOD's efforts to reduce mental health stigma.

We used information from our interviews with officials from the above organizations as well as our information from our focus groups to identify policies that these officials believed to be adding to the existence of stigma, may contain restrictive language, or may be based on out-of-date information. Additionally, we supplemented and corroborated our testimonial evidence from our interviews with the 2014 RAND Corporation report, *Mental Health Stigma in the Military*,[7] and concluded that the report was sufficiently reliable for using the report's conclusions and recommendations as part of our report.

Further, we obtained and reviewed DOD policies on issuing, suspending, and revoking personnel security clearances and interviewed officials from the Office of the Under Secretary of Defense for Intelligence to discuss eligibility for personnel security clearances, the DOD Consolidated Adjudications Facility, the Defense Office of Hearings and Appeals, and security managers at the four installations we visited to determine their interpretations of the policies as well as any local implementation practices related to the management of personnel security clearances.

To determine the extent to which DOD is positioned to measure the progress of its efforts to reduce mental health care stigma, we used the surveys and stigma-related questions discussed previously, DOD and service policies, and DOD task force and other and reviewed them for the

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[7] The RAND Corporation, *Mental Health Care Stigma in the Military*, (2014).

existence of definitions of stigma, goals associated with any efforts to address stigma, and any performance measures related to those goals. We assessed them against government performance and management practices that state agencies should establish performance goals in an objective, quantifiable and measurable form, and that they should be defined with sufficient precision to permit ready assessment of progress in meeting that goal.[8] Additionally, we used the *Standards for Internal Control in the Federal Government* which states that agency should use quality information to achieve their objectives.[9]

We also compared the methodologies and administration of the surveys we found to have stigma related questions to federal standards for statistical surveys that require the use of consistent data collection procedures in order to maintain a consistent data series over time.[10] Further, we identified through literature reviews and interviews the DOD- and service-level offices and organizations that have either direct responsibilities for reducing stigma specified in policies or in their mission statements or are involved in stigma as a collateral function even if not charged with such responsibilities directly. We compared our results with the *Standards for Internal Control in the Federal Government* which requires the assignment of responsibility and delegation of authority to achieve agency objectives. To corroborate our understanding of the roles and missions of each of the organizations we identified as being involved in mental health stigma related efforts, we conducted interviews with officials within DOD and the services.

We conducted this performance audit from June 2015 to April 2016 in accordance with generally accepted government auditing standards. These standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

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[8] Pub. L. No. 111-352, 124 Stat. 3866 (2011). The GPRA Modernization Act of 2010 amends the Government Performance and Results Act of 1993, Pub. L. No. 103-62, 107 Stat. 285 (1993).

[9] GAO-14-704G.

[10] Office of Management and Budget, *Standards and Guidelines for Statistical Surveys* (September 2006).

Appendix II: Focus Group Methodology and Results

To obtain the perceptions of servicemembers and deployable Department of Defense (DOD) civilian personnel related to (1) the existence of stigma associated with seeking mental health care; (2) the commanded climate in support of seeking mental health care; and (3) any training, education and other resources that exist to reduce stigma or provide mental health care to those in search of help, we conducted 26 focus group sessions at six locations. We selected and conducted site visits at four geographically dispersed installations - one for each of the four military services: the Navy: Joint Base Little Creek-Fort Story, Virginia; the Marine Corps: Camp Lejeune, North Carolina; the Air Force, Scott Air Force Base, Illinois; and the Army: Fort Drum, New York. Additionally, we selected Camp Atterbury, Indiana to meet with two groups of civilians because that location had civilians who were undergoing pre-deployment training, and we selected the Pentagon to meet with one group of civilians who had previously deployed and had since returned. To obtain a cross section of perceptions, our point of contact at each location worked to identify and recruit multiple participants for each of our groupings. We stipulated only that we wanted to try to have approximately 8 to 10 participants in each group and that the participants should be enlisted for the respective group based on their rank and rates for the following six groups: E1 to E3, E4 to E6, E7 and E8, O1 to O3, O4 to O5, and O6 and E9[1]. We grouped E9s and O6s because they are the senior leaders on both the enlisted and officer sides, and we believed that, together, they would give the appropriate leadership perspectives of stigma associated with seeking mental health care. Due to the low number of O6s and E9s at Joint Base Little Creek-Fort Story, we interviewed those servicemembers and did not hold a focus group session with those participants at that location. Additionally, no grade stipulations were made for participants in the civilian focus groups-only that they have had or were preparing to have deployment experience. Overall, the 23 focus groups with active duty servicemembers and the 3 focus groups with civilians ranged in size from five to thirteen participants. Because we did not select participants using a statistically representative sampling method, the information provided in these focus group sessions is nongeneralizable and therefore cannot be projected across DOD, a military service, or any single installation we visited.

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[1] The "E" stands for enlisted rank and the "O" stands for a commissioned officer. The number represents the pay grade of the servicemember at that rank. E1 is the lowest enlisted position, and O1 is the lowest officer position.

To conduct the focus groups, a trained GAO facilitator moderated each of the sessions, following a protocol that included prompts, instructions to the participants, and a set of six questions, each with several specific follow up questions to be used as needed. In addition to discussing in a focus group setting servicemembers' and deployed civilians' perceptions of stigma associated with seeking mental health care in a focus group setting, we administered a 2-page survey to each participant at the end of each session before the participants were dismissed. This survey instrument included questions of a sensitive nature that might not be conducive to an open discussion with others present. The focus group protocol and the survey instrument were validated by GAO methodologists with social science backgrounds and knowledge of small group methods and survey administrations. In addition, both the focus group protocol and the survey instrument were pre-tested at our first site visit. The same focus group protocol was used at the remaining military installations; however, we made minor but necessary modifications to the protocol for our sessions with the civilians to be applicable. Further, the same survey instrument was administered to all participants in all 26 focus groups, though we made some minor but necessary modifications to the survey instrument to ensure applicability in civilian focus groups. Though not generalizable beyond participants in the focus groups, the focus group questions that the GAO moderator asked the participants are listed in table 5.

Table 5: Focus Group Questions the GAO Moderator Asked Participants during Focus Group Sessions[a]

1.	By a show of hands, do you think there is a stigma associated with seeking mental health care treatment?
2.	What are some of the reasons, if any, military servicemembers (or DOD civilians) may be reluctant to seek mental health care services (in connection with deployment experiences)?
3.	Overall, do you feel leaders (military and civilian) in this command (or agency) are supportive or not supportive of military servicemembers (or personnel) seeking mental health care treatment?
4.	What impact, if any, do you think seeking mental health care treatment could have on a servicemember's career (or the career of a civilian who has deployed)?
5.	What other barriers or challenges do you think may exist that would discourage a servicemember (or civilian employee) from seeking mental health care that have not been mentioned in this session?
6.	What resources are you aware of to reduce the stigma or improve the perceptions of seeking mental health care?

Source: GAO |GAO-16-404

[a]Questions include variations used for deployed DOD civilians' focus groups in parentheses.

Following our focus group sessions, we completed a final record of the participants' comments from each of the sessions. Next, we conducted a content analysis to analyze the final records of each focus group to identify themes that participants expressed across all or most of the

groups. To do this, the team developed a set of themes after reviewing participants' comments from the focus groups. After agreeing to a final set of themes, one analyst initially coded all of the comments. Following this initial coding, a second analyst reviewed the coding and agreed or disagreed. Where there were discrepancies, a third analyst made the final decision as to which theme(s) the comment would be included. See table 6 for the results of our analysis.

Table 6: Results of Our Analysis of Themes Identified in Focus Group Sessions with Servicemembers and DOD Deployed Civilians *(Answers are shown as the number of focus groups within each category in which the given theme was discussed)*

Focus group	E1 to E3	E4 to E6	E7 to E8	O1 to O3	O4 to O5	E9 and O6	Civilian	Total
Total # of Groups convened by rank	**4**	**4**	**4**	**4**	**4**	**3**	**3**	
Theme: Reasons for not seeking care								
Possibly losing security clearance	2	3	3	4	4	3	3	**22**
Possibly losing needed qualifications to do job	2	4	4	4	4	3	1	**22**
Not qualifying for special assignments or schools	0	4	3	1	1	3	2	**14**
Being harassed by peers as being weak	4	4	3	1	2	3	3	**20**
Lack of confidentiality or mandatory reporting to leadership	2	2	4	4	2	2	1	**17**
Lack of privacy in seeking help on base	3	3	3	4	4	1	1	**19**
Being associated with malingers who abuse the mental health system	3	4	4	3	4	3	0	**21**
Lack of confidence that it would help anything	2	2	2	1	1	3	1	**12**
Having to miss work to go to appointments	3	4	3	3	3	2	2	**20**
Having to live up to competitive military image	3	4	4	3	2	3	3	**22**
Possible negative impact on career advancement decisions	3	4	4	4	4	3	3	**25**
Possibly losing ability to carry / use a firearm	1	4	2	2	1	3	1	**14**
General uncertainty about potential consequences of seeking mental health care	2	3	3	2	2	2	3	**17**
Other reason, barriers	4	4	4	4	4	3	3	**26**
Theme: Command climate								
Supportive of seeking help	4	4	4	4	4	3	3	**26**
Proactively promotes seeking help	1	2	2	3	3	2	0	**13**
Encouraging in order to cover themselves	0	2	3	3	3	1	2	**14**
Encourages subordinates but would not go themselves	1	1	1	3	1	1	0	**8**
Has to take everyone seriously due to hypersensitivity to suicide possibility/military regulations	2	3	4	3	3	1	1	**17**
Wants everyone to be at their best to help unit readiness	3	3	2	2	1	2	0	**13**

Focus group	E1 to E3	E4 to E6	E7 to E8	O1 to O3	O4 to O5	E9 and O6	Civilian	Total
Hard to know what is really happening with all in the unit	1	0	2	2	1	0	0	**6**
Other command climate	4	4	4	4	4	3	3	**26**
Theme: Possible sources of care								
Military mental or behavioral health care providers	4	3	4	3	4	3	2	**23**
Military primary care providers	1	2	2	0	2	0	0	**7**
Military OneSource counselors	2	1	4	2	3	1	1	**14**
Military and Family Life counselors	2	3	3	3	4	3	0	**18**
Military chaplains	2	3	3	0	3	2	2	**15**
Friends or peers	2	3	3	1	3	2	2	**16**
Resiliency related training courses	4	4	4	3	4	3	2	**24**
Other resources	4	4	3	4	4	3	3	**25**
Total								

Source: GAO analysis of focus group responses |GAO-16-404

Note: The "E" stands for enlisted rank and the "O" stands for a commissioned officer. The number represents the pay grade of the servicemember at that rank. E1 is the lowest enlisted position, and O1 is the lowest officer position. Focus groups were convened by rank. For example, we interviewed four focus groups that comprised E1s to E3s.

The information that we obtained during these focus groups accurately captures the opinions provided by the servicemembers and DOD federal civilian employees who attended the focus groups at the six locations we visited. However, these opinions cannot be generalized to all servicemembers or DOD civilians at these locations or to all servicemembers and DOD civilians across the department.

To obtain additional servicemember and DOD deployed civilians' perceptions related to seeking mental health care, each focus group participant was administered a survey instrument prior to leaving the focus group meeting. The questions and instructions are shown below along with the results for the closed-ended questions. Variations to civilian survey questions are noted in parentheses.

Survey of Army, Navy, Air Force, Marine Corps, and Deployed Civilians Focus Group Participants

Instructions: Please answer the following questions and place your completed survey back in the envelope provided. In order to maintain anonymity, please do not write your name anywhere on this survey.

1. **How likely, if at all, would you be to seek mental health services
   if you were experiencing the following situations:** *(Mark only one
   response for each row a through h) Answers shown as number of
   respondents across all locations.*

Situation ▼	Not at all likely ▼	Some what likely ▼	Very likely ▼	Unsure/ Don't Know ▼
a) Anxiety, Worry, Concerns				
Servicemembers (n= 186)	80	63	40	3
Civilians (n=22)	15	6	0	1
b) Depression				
Servicemembers (n= 186)	44	81	55	6
Civilians (n=22)	10	10	1	1
c) Distress related to family issues				
Servicemembers (n= 186)	65	72	44	5
Civilians (n=22)	13	7	1	1
d) Distress related to relationship				
Servicemembers (n= 186)	75	68	38	5
Civilians (n=22)	14	7	1	0
e) Grief, Sorrow, Unhappiness				
Servicemembers (n= 184)	66	65	45	8
Civilians (n=22)	13	8	1	0
f) Job-related stress				
Servicemembers (n= 185)	100	48	31	6
Civilians (n=20)	13	6	1	0
g) Post-Traumatic Stress Disorder				
Servicemembers (n= 186)	20	40	117	9
Civilians (n=21)	6	5	8	2
h) Substance abuse (alcohol or drugs)				
Servicemembers (n= 186)	43	53	82	8
Civilians (n=22)	9	8	4	1

Source: GAO | GAO-16-404

2. **How likely, if at all, would you be to seek care with the following
   providers (for help with deployment-related stress or
   experiences)?** (*Mark only one response for each row a through e)
   Answers shown as number of respondents.*

Provider ▼	Not at all likely	Some what likely ▼	Very likely ▼	Unsure/ Don't Know ▼
a) Military Chaplain				
Servicemembers (n= 186)		32	65	87	2
Civilians (n=22)	6	9	6	1
b) Military and family life counselor				
Servicemembers (n= 186)	38	76	68	4
Civilians (n=22)	11	8	2	1
c) Military psychologist or psychiatrist				
Servicemembers (n= 185)	56	72	53	4
Civilians (n=22)	12	6	2	2
d) Military primary care doctor				
Servicemembers (n= 185)	47	66	70	2
Civilians (n=22)	11	7	3	1
e) Non-military civilian mental health counselor or other provider				
Servicemembers (n= 186)	35	73	69	9
Civilians (n=25)	7	7	7	4

Source: GAO | GAO-16-404

3. **Why would you select certain types of providers over other types of providers?**

4. **What would be your main concerns, if any, about seeking mental health treatment if you needed it (in connection with your deployment experiences)?**

5. **What thoughts come to mind regarding an individual who is receiving treatment for a mental health condition?**

6. **If you were to seek treatment from a military mental healthcare provider, how concerned, if at all, would you be about your senior leader (or civilian senior leaders from your agency or from the military) finding out?** *(Mark only one response.) Answers shown as number of respondents.*

☐Not at all concerned	
Servicemembers	80 out of 187
Civilians	4 out of 21
☐Somewhat concerned	
Servicemembers	54 out of 187
Civilians	1 out of 21
☐Moderately concerned	
Servicemembers	25 out of 187
Civilians	*Civilians*
☐Very concerned	
Servicmembers	28 out of 187
Civilians	13 out of 2

Source: GAO | GAO-16-404

7. **How supportive, if at all, do you believe your commander (or senior leaders) is of mental health treatment?** *(Mark only one response ☒) Answers shown as number of respondents.*

☐Not at all supportive	
Servicemembers	1 out of 187
Civilians	4 out of 20
☐Somewhat supportive	
Servicemembers	20 out of 187
Civilians	10 out of 20
☐Moderately supportive	
Servicemembers*:*	29 out of 187
Civilians	2 out of 20
☐Very supportive	
Servicemembers*:*	137 out of 187
Civilians	4 out of 20

Source: GAO | GAO-16-404

8. **Have you or someone you know experienced the following situations as a result of seeking mental health treatment?** *(Mark only one response in each row.) Answers shown as number of respondents.*

		Yes ▼	No ▼	Unsure ▼
a)	Delayed promotion			
	Servicemembers (n= 186)	21	131	34
	Civilians (n=21)	2	11	8
b)	Denied a training opportunity			
	Servicemembers (n= 186)	66	96	24
	Civilians (n=21)	3	11	7
c)	Detailed to a less preferred assignment			
	Servicemembers (n= 186)	64	100	22
	Civilians (n=21)	8	7	6
d)	Demoted			
	Servicemembers (n= 186)	8	162	16
	Civilians (n=21)	1	12	8
e)	Discharged from the military (or terminated from employment)			
	Servicemembers (n= 186)	69	98	19
	Civilians (n=21)	3	12	6
f)	Sought a different employment opportunity			
	Servicemembers	n/a	n/a	n/a
	Civilians (n=19)	7	6	6

Source: GAO | GAO-16-404

**Are there any additional thoughts or comments you would like to
share related to any issues in the focus group session or related to
the stigma of mental health services for military servicemembers (or
deployed civilian personnel)?**

Appendix III: Reports and Studies Related to Mental Health Care Stigma Issued by the Department of Defense, the Military Services, and Other Organizations

Department of Defense (DOD) task forces, the military services, and organizations outside DOD have produced reports and studies that addressed issues associated with mental health care stigma in the military, including the following:

- **Mental Health Advisory Team (MHAT) Studies (2003-2013).**

  The Army has sponsored a series of MHAT studies beginning in 2003 using a survey instrument developed by the Walter Reed Army Institute of Research (WRIAR) to assess behavioral health and well-being among soldiers and marines in maneuver unit platoons in combat theater in Afghanistan and Iraq. The effort produced nine reports, utilizing a consistent survey instrument that allowed for year-to-year comparisons in order to detect trends, although trend analysis is somewhat hampered by adjustments made to the sampling design of the studies in 2009. However, the Army's analysis of trends from 2009 to 2013 showed that stigma remained fairly stable across studies. Based on the most recent MHAT reports, the Army reported in 2013 that soldiers and marines in combat settings who screen positive for mental health problems on a survey instrument report greater stigma than those who do not screen positive.[1] Specifically, of E1-E4 soldiers in theater 7 months and male E1-E3 marines in theater 4.5 months, an estimated 49 percent and 61 percent, respectively, of those who screen positive for mental health problems reported that concerns about being seen as weak affected their decision to receive mental health care services, as opposed to 24 percent and 28 percent respectively of those who did not screen positive for mental health problems. Officials told us that in more recent years, efforts have been made to apply the MHAT study model to populations of servicemembers in additional home-based and other theater locations.

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[1] Office of the Surgeon General, U.S. Army Medical Command, *Mental Health Advisory Team 9 (MHAT 9) Operation Enduring Freedom (OEF) 2013 Afghanistan,* (Oct. 10, 2013); Office of the Surgeon General, US Army Medical Command, *Mental Health Advisory Team 8 (J-MHAT 8) Operation Enduring Freedom (OEF) 2012 Afghanistan,* (Aug. 12, 2013).The survey used in the MHAT screens respondents for mental health problems, including acute stress, depression and anxiety.

**Appendix III: Reports and Studies Related to
Mental Health Care Stigma Issued by the
Department of Defense, the Military Services,
and Other Organizations**

- **2007 DOD Task Force on Mental Health.**

  In a June 2007 report to Congress, DOD stated that maintaining the psychological health, enhancing the resilience, and ensuring the recovery of servicemembers and their families are essential to maintaining a ready and fully capable military force.[2] Toward that end, a task force on mental health in DOD established a vision involving, among other things, a goal of creating a culture of support for psychological health, wherein all servicemembers and leaders will be educated to understand that psychological health is essential to overall health and performance. The task force concluded that stigma in the military remains pervasive and often prevents servicemembers from seeking needed care.

- **2008 RAND Corporation study:** *Invisible Wounds of War: Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recovery.*

  In 2008, the RAND Corporation issued a report aimed at addressing gaps in knowledge about the mental health and cognitive needs of servicemembers returning from Afghanistan and Iraq, the adequacy of the care systems available to meet those needs, the experience of veterans and servicemembers who are in need of services, and factors related to whether and how injured servicemembers and veterans seek care.[3] As part of this report, the RAND Corporation notes that stigma refers to various types of social, cultural, and personal factors affecting access to mental health care.

- **2010 DOD Task Force on the Prevention of Suicide by Members of the Armed Forces.**

  Congress mandated DOD in the National Defense Authorization Act for Fiscal Year 2009 to establish a task force to examine matters relating to the prevention of suicide by members of the armed forces.[4] The final report of this task force developed 76 targeted

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[2] Department of Defense, *An Achievable Vision: Report of the Department of Defense Task Force on Mental Health* (2007).

[3] The RAND Corporation, *Invisible Wounds of War: Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recovery* (2008).

[4] Duncan Hunter National Defense Authorization Act for Fiscal Year 2009, Pub. L. No. 110-417, div. A, § 733 (Oct. 14, 2008).

recommendations, 13 of which it designated Foundational Recommendations considered critically important to the success of developing a comprehensive DOD suicide prevention model.[5] Among other things, the task force recommended developing a comprehensive stigma reduction campaign plan that attacks the issue of suicide prevention on multiple fronts to encourage help-seeking behavior and normalizes the care incurred by servicemembers. The report stated that DOD's challenge of preventing suicide and sustaining suicide prevention efforts involves addressing the large set of psychological, physical, spiritual, emotional, relational, environmental, occupational and social stressors that exist in a person's life, as well as building resiliency and reducing stigma, which influence the impact of those stressors.

- **2011 RAND Corporation Study: Promoting Psychological Resilience in the U.S. Military.**

  In 2011, the RAND Corporation published a report detailing the results of its research to assist DOD in understanding methodologies that could be useful in promoting resilience—the ability to recover from or adjust easily to misfortune or change—among servicemembers and their families.[6] The report stated that without strong leadership, military resilience programs cannot be successful, because leadership can play a pivotal role in creating a command climate in which it is okay to get help for psychological health concerns. However, current policy could promote cultural attitudes and beliefs that inhibit acknowledging problems and seeking mental health care.

- **2013 Institute of Medicine of the National Academies Report.**

  In 2008, the Institute of Medicine of the National Academies was tasked with conducting a study that resulted in a final report in 2013 that stated, among other things, that stigma is a problem for military personnel receiving care or seeking care for mental health or

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[5] Department of Defense, *The Challenge and the Promise: Strengthening the Force, Preventing Suicide and Saving Lives; Final Report of the Department of Defense Task Force on the Prevention of Suicide by Members of the Armed Forces* (August 2010).

[6] The RAND Corporation, *Promoting Psychological Resilience in the U.S. Military* (2011).

**Appendix III: Reports and Studies Related to
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and Other Organizations**

substance abuse problems.[7] According to this report, active duty servicemembers fear that visiting a mental health care provider will jeopardize their careers because of the military's long-standing policy of reporting these types of problems through the chain of command. Additionally, the report stated that mixed messages about seeking treatment and concerns about health information privacy remain disincentives to seeking care and that barriers to seeking mental health care treatment include stigma; concern about effects on career; and perceptions of commanders, units, and peers.

- **2013 Air Force Community Assessment survey.**

  The 2013 Air Force Community Assessment is not specific to mental health care stigma, but does contain several questions relevant to stigma. Based on the most recent Air Force Community Assessment Study in 2013, the Air Force reported that stigma exists among active and reserve component airmen, and that perceptions vary depending on the provider type. Based on analysis of its own survey data, the Air Force reported that an estimated 14 percent of active duty airmen, 19 percent of Air Force reservists, and 16 percent of Air National Guard members believe that seeking mental health care would unfavorably impact their career. Approximately 4 percent of active duty airmen believe that seeing a military chaplain would hurt their career, while about 37 percent of active duty airmen believe that seeing a military mental health care professional would hurt their career.[8] Table 7 summarizes the Air Force's findings about levels of perceived stigma by component and provider type.

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[7] Institute of Medicine of the National Academies, *Returning Home from Iraq and Afghanistan: Assessment of Readjustment Needs of Veterans, Service Members, and Their Families* (Washington, D.C.: 2013).

[8] U.S. Air Force, *2013 Air Force Community Assessment USAF Survey Results, AF Active Duty Overall Report*, (February 2014); U.S. Air Force, *2013 Air Force Community Assessment USAF Survey Results, AF Reserve- Overall Report,* (February 2014); U.S. Air Force, *2013 Air Force Community Assessment USAF Survey Results, AF Guard- Overall Report,* (February 2014)

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Table 7: Percentage of U.S. Air Force Members Surveyed Who Believe that a Servicemember's Career Would Be Hurt a Little or Hurt a Lot by Seeking Mental Health Care by Provider Type

Type of mental health care provider	Active duty	Air Force reserve	Air Force guard
Military chaplain	4%	7%	8%
Military mental health professional[a]	37	41	33
Civilian mental health professional[b]	28	28	24
Military OneSource[c]	6	8	8
Airmen and Family Readiness Center staff[d]	9	12	12
Military Family Life consultants[e]	9	14	14

Source: Air Force Community Assessment Survey, 2013. | GAO-16-404

Note: The Air Force Community Assessment Survey for 2013 did not define any of the provider types beyond the terms listed in the table. Definitions below reflect how those terms are generally applied in DOD.

[a]According to the Air Force, military mental health care professionals generally include mental health providers working in the installation's military treatment facility (MTF).

[b]According to the Air Force, civilian mental health care professionals generally refers to mental health providers not associated with the installation or MTF—for example, local community mental health providers.

[c]Military OneSource is a DOD-funded program available to all servicemembers (including the National Guard and reserve component) and their families. The program provides confidential, short-term, nonmedical counseling services both face-to-face and remotely, and information and resources on deployments, parenting, and relationships, among other things.

[d]Airman and Family Readiness Center staff provide information, referrals, and services such as deployment planning and suppor;, personal financial management;, and support for wounded, ill, and injured airmen and their families, among other things.

[e]Military Family Life consultants provide worldwide, nonmedical, face-to-face counseling to any servicemember and their family.

The Air Force utilized different sampling methodologies by population in administering this survey. These results are based on random sample, weighted survey data.

- **2014 RAND Corporation Report: Mental Health Stigma in the Military.**

  In 2014, the RAND Corporation published a report detailing its efforts to inventory and assess stigma-reduction strategies across both the services and DOD as a whole and to identify strengths and gaps that should be addressed.[9] The report contains six findings from the

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[9] The RAND Corporation, *Mental Health Stigma in the Military* (2014).

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content analysis of DOD policies. First, tensions exist between the need for privacy of servicemembers seeking mental health treatment and the need for commanders to assess unit fitness. Second, despite the presence of equal-opportunity policies, wide variability and ambiguity exist in DOD policies that prohibit servicemembers with mental health disorders from pursuing career opportunities and may inadvertently create opportunities for discrimination. Third, policies support universal educational stigma-reduction programs but not more targeted programs for those in or in need of mental health treatment. Fourth, some policies could potentially reinforce stereotypes through the use of negative terminology. Fifth, other policies may expose servicemembers to stigma or discrimination because they allow nonmental health care professionals to determine mental health fitness. Finally, mental health screening is beneficial for early intervention but, if used improperly, may be stigmatizing and have negative effects on mental health.

Appendix IV: Department of Defense- and Military Service-Sponsored Survey Instruments and Their Questions Related to Mental Health Care Perceptions

Our review of Department of Defense (DOD)- and military service-sponsored survey instruments that included questions related to perceptions about mental health care found that surveys utilize a variety of proxy measures to gauge mental health care stigma in the military. Table 8 below details the questions related to mental health stigma from the surveys we reviewed.

Table 8: Survey Instruments and Related Questions Regarding Mental Health Care Perceptions

Survey (year)	Questions

2015 DOD Health Related Behaviors Survey of Active Duty Service Members (2015)	• You said you needed counseling, therapy, or treatment in the PAST 12 MONTHS, but that you did not receive it from any source on our list. Why didn't you receive counseling, therapy or treatment? Please select ALL THAT APPLY. [Ask if Q100 OR Q101 = Yes (1) and all responses to Q102 (A-H) are NO (2). Randomize.]
	  5. It would have harmed my career.
	  6. I could have been denied security clearance in the future.
	  8. I was afraid my supervisor/unit leadership would have a negative opinion of me.
	  9. My commander or supervisor asked me/us not to get treatment.
	  10. My coworkers would have had less confidence in me if they found out.
	  11. I was concerned that the information I gave the counselor might not be kept confidential.
	  14. Other*
	  Listed among other possible barriers to mental health care
	
	• In general, do you think it would damage a person's military career if the person were to seek counseling or mental health therapy/treatment through the military, regardless of the reason for seeking counseling?
	  1. Yes
	  2. 2No

2011 Health Related Behaviors Survey of Active Duty Military Personnel (2011-2012)	• In general, do you think it would damage a person's military career if the person were to seek counseling or mental health therapy/treatment through the military, regardless of the reason for seeking counseling?
	  1. 1. It definitely would damage a person's career
	  2. It probably would damage a person's career
	  3. It probably would NOT damage a person's career
	  4. It definitely would NOT damage a person's career
	
	• IF you received mental health services through the military, how did it affect your career?
	  1. Very positively
	  2. Somewhat positively
	  3. Neither positively nor negatively
	  4. Somewhat negatively
	  5. Very negatively
	  6. I did not receive any mental health services through the military

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Instruments and Their Questions Related to
Mental Health Care Perceptions**

Survey (year)	Questions

2010-2011 Department of Defense Health Related Behaviors Reserve Component Survey (2010-2011)	• If you were interested in seeking mental health/substance abuse counseling or therapy, did you experience any of the following? (respondents select Yes, No, or N/A)
	
	    Personnel that seek counseling or therapy are seen as weak in my unit*
	
	    *Listed among other possible barriers to mental health care
	
	• My chain of command is supportive of personnel seeking mental health services when they are needed.
	
	    Strongly agree
	
	    Agree
	
	    Disagree
	
	    Strongly disagree
	
	• Do you think it would damage a person's military career to seek counseling or therapy <u>through the military</u>, regardless of the reason for seeking counseling?
	
	    1. It <u>definitely would</u> damage a person's career
	
	    2. It <u>probably would</u> damage a person's career
	
	    3. It <u>probably would NOT</u> damage a person's career
	
	    4. It <u>definitely would NOT</u> damage a person's career

Defense Equal Opportunity Management Institute (DEOMI) Organizational Climate Survey (FY2015)	• Seeking help for depression, suicidal thoughts, or PTSD is a sign of strength. • Seeking help for depression, suicidal thoughts, or PTSD would negatively impact a member's career. Response Scale: 1 = Strongly Disagree 2 = Disagree 3 = Agree 4 = Strongly Agree
2014 Status of Forces Survey of Active Duty Members (2014)	• Below is a list of concerns some members have about counseling. To what extent did/ would these concerns factor into your decision regarding counseling? Mark one answer for each item. c. It would be too embarrassing. e. It would harm my career. f. It would be seen as weak.* *Listed among other possible barriers to mental health care <u>Response Scale:</u> • Very large extent • Large extent • Moderate extent • Small extent • Not at all

**Appendix IV: Department of Defense- and
Military Service-Sponsored Survey
Instruments and Their Questions Related to
Mental Health Care Perceptions**

Survey (year)	Questions

2013 Air Force Community Assessment (2013)	• **Subtopic: Impact of Professional Mental Health Services on Career**
	
	  • For personal problems or serious troubles, how much do you think that USAF members' careers would be helped or hurt if they saw [SERVICE PROVIDER] for their personal problems or serious troubles?
	
	  Service providers: Military chaplain, Military Mental Health Professional, Civilian Mental Health Professional, Military One-Source, Airmen and Family Readiness Center Staff, Military Family Life Consultants
	
	  <u>Response Scale:</u>
	• Careers would be helped a lot
	• Careers would be helped a little
	• Careers would not be affected
	• Careers would be hurt a little
	• Careers would be hurt a lot
	
	• Subtopic: Barriers to Treatment- Institutional Stigma
	
	  • How likely would the following concern deter you from seeking counseling or mental health care services?
	    • Mental health treatment in the military is confidential
	    • Seeking mental health care would hurt my career
	    • How likely do you think that seeking professional behavioral health counseling/care for psychological problems would have a negative impact on a Service member's career?
	    • If a Service member in your unit sought professional counseling/care for an emotional or personal problem, how likely would it be that the treatment would be kept confidential?
	    • If a Service member in your unit sought professional counseling/care for an emotional or personal problem, how likely would it be that the Chain of command would be supportive?
	
	  <u>Response Scale:</u>
	• Absolutely certain
	• Very likely
	• Somewhat likely
	• Not at all likely
	
	• Subtopic: Barriers to Treatment- Peer Stigma
	
	• If a Service member in your unit sought professional counseling/care for an emotional or personal problem, how likely would it be that the co-workers would criticize or make fun of them?
	• If a Service member in your unit sought professional counseling/care for an emotional or personal problem, how likely would it be that the co-workers would have less confidence in them?
	• If a Service member in your unit sought professional counseling/care for an emotional or personal problem, how likely would it be that the supervisors would have less confidence in them?
	• How likely would the following concern deter you from seeking counseling or mental health care services? Coworkers would look down on me if I sought mental health treatment.
	
	  <u>Response Scale:</u>
	• Absolutely certain
	• Very likely

Appendix IV: Department of Defense- and
Military Service-Sponsored Survey
Instruments and Their Questions Related to
Mental Health Care Perceptions

Survey (year)	Questions
	• Somewhat likely
	• Not at all likely

Mental Health Advisory Team 9 (MHAT 9) Operation Enduring Freedom (OEF) 2013 Afghanistan (2013) and
 	
Joint Mental Health Advisory Team 8 (J-MHAT 8) Operation Enduring Freedom 2012 Afghanistan (2012)
	• If a Service Member in your unit sought counseling/care for an emotional or personal problem, how likely or unlikely is it that their…
	  • Treatment would be kept confidential?
	  • Co-workers would criticize or make fun of them?
	  • Co-workers would have less confidence in them?
	  • Supervisors would have less confidence in them?
	  • Chain of Command would be supportive?
	  <u>Response Scale:</u>
	  • Very likely
	  • Likely
	  • Neither likely nor unlikely
	  • Unlikely
	  • Very Unlikely
	• Rate each of the following factors that might affect your decision to receive mental health counseling or services if you ever had a problem during this deployment: (*stigma items, listed among others*)
	  • My unit leadership might treat me differently.
	  • Members of my unit might have less confidence in me.
	  • I would be seen as weak.
	  • My leaders would blame me for the problem.
	  • It would harm my career.
	  • It would be too embarrassing.*
	  Listed among other possible barriers to mental health care
	  <u>Response Scale:</u>
	  • Strongly Disagree
	  • Disagree
	  • Neither Agree Nor Disagree
	  • Agree
	  • Strongly Agree

Source: GAO analysis of DOD information. | GAO-16-404

Note: Dates in parentheses represent years in which the survey was administered.

Appendix V: Comments from the Department of Defense

THE ASSISTANT SECRETARY OF DEFENSE

1200 DEFENSE PENTAGON
WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

APR 1 1 2016

Ms. Brenda Farrell
Director, Defense Capabilities Management
U.S. Government Accountability Office
441 G Street, NW,
Washington, DC 20548

Dear Ms. Farrell:

This is the Department of Defense (DoD) response to the Government Accountability Office (GAO) Draft Report, GAO-16-404, "HUMAN CAPITAL: Additional Actions Needed to Enhance DoD's Efforts to Address Mental Health Care Stigma," dated March 1, 2016 (GAO Code 352042). Thank you for the opportunity to review and comment on the Draft Report. My comments to the recommendations are enclosed.

Following the Statement of Facts exit conference on February 22, 2016, DoD submitted substantive comments and suggested corrections which were submitted directly to GAO on February 25, 2016. In addition, technical comments in response to the final draft report were submitted to GAO by direct email on March 29, 2016, and again on April 4, 2016, in accordance with the DoD Office of the Inspector General protocol to not include these in my final response. I appreciate GAO's willingness to consider these comments in an effort to reduce possible misinterpretation and improve the accuracy of the report.

My points of contact for this matter are Captain Robert DeMartino (functional) who may be reached (703) 681-3611 or at robert.e.demartino.mil@mail.mil and Ms. Joyce Forrest (audit liaison) at (703) 681-6741 or at joyce.forrest2.civ@mail.mil.

Jonathan Woodson, M.D.

Enclosures:
As stated

GOVERNMENT ACCOUNTABILITY OFFICE (GAO) DRAFT REPORT DATED
MARCH 1, 2016
GAO-16-404 (GAO CODE 352042)

"HUMAN CAPITAL: ADDITIONAL ACTIONS NEEDED TO ENHANCE DOD'S
EFFORTS TO ADDRESS MENTAL HEALTH CARE STIGMA"

DEPARTMENT OF DEFENSE (DoD) COMMENTS
TO THE GAO RECOMMENDATIONS

GENERAL COMMENTS:

Absence of an agreed upon definition of "stigma" and widespread disagreement in how to
measure this cultural phenomenon reflects the origins of this lay term in the vernacular and
varying interpretations of its consequences on behavior as revealed in both civilian and military
research settings. This has made GAO's work in performing this audit all the more difficult. The
report would have been strengthened by also describing the stigma perceived by Service
members related to seeking care for physical health conditions that are incompatible with
military service as well as the experience of stigma experienced by civilians in highly sensitive,
high risk occupations.

The DoD's efforts to address mental health care stigma can be compared to its efforts in the area
of resilience. The DoD has used the concept of resilience, another concept adopted from the
vernacular, to explore interventions to strengthen the ability of our Service members to weather
the many stresses of military life. In much the same way, DoD has adopted the concept of stigma
to explore the perceptions and behaviors of Service members with regard to seeking, receiving
and following through with mental health care. As a result, DoD efforts are directed at ensuring
adequate treatment capacity, increasing access in primary care and Embedded Behavioral Health,
and ensuring that Service members get the intensity and duration of care needed to achieve
meaningful, measurable, outcomes. Whether or not individuals perceive stigma to be present is
less important than whether or not they seek care when needed despite their perception. Stigma
surrounding mental health is pervasive in society and has certainly not spared the military, but
emerging research[123] indicates that stigma itself is not necessarily of critical importance to the
decision people make whether or not to seek or not access care. For example, recent literature
reports that a person's need to handle problems on their own [self-sufficiency] appears to also be
an important deterrent to seeking care.

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[1] Quartana, P.J; Wilk, J.E.; Thomas, J.L.; Bray, R.M.; Rae Olmsted, K.L. : Brown, J.M.; Williams, J.;
Kim, P.Y; Clarke-Walper, K.; Hoge, C.W. *Trends in Mental Health Services Utilization and Stigma in
US Soldiers from 2002 to 2011*. Published online ahead of print July 17, 2014 | American Journal of
Public Health, Research and Practice
[2] Hoge, C.W.; Grossman, S.H.; Auchterlonie, J.L.; Milliken, C. S.; Wilk, J.E. *PTSD Treatment for
Soldiers After Combat Deployment: Low Utilization of Mental Health Care and Reasons for Dropout*.
PSYCHIATRIC SERVICES ' ps.psychiatryonline.org ' August 2014 Vol. 65 No. 8
[3] Adler, A. B.; Britt, T.W.; Riviere, L.A; Kim, P.Y; Thomas, J.L. *Longitudinal determinants of mental
health treatment-seeking by US soldiers*. The British Journal of Psychiatry, 2015 Oct;207(4):346-50

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Some of the health surveys of our Service members are created and administered by the
individual Services; others are administered by the Department for use with all Service members.
There is agreement within the DoD and work underway toward achieving the goal to have at
least one DoD-wide survey that incorporates a consistent series of questions that will permit
DoD to track and trend attitudes about stigma over time. The 2011, 2014, and 2015 DoD Health
Related Behaviors Surveys (HRBS) each ask about need for and utilization of mental health
counseling or therapy, and about perceived impact of receiving mental health care on one's
military career. Further, the 2015 HRBS asks about reasons for not seeking mental health care, if
such care is needed, including concerns about security clearance or negative opinions by military
supervisor or unit leadership and co-workers. The continued attention to these issues in the
HRBS reflects DoD's ongoing commitment to measure these perceptions.

RECOMMENDATION 1: The GAO recommends that the Secretary of Defense (SecDef)
direct the Under Secretary of Defense for Personnel and Readiness (USD(P&R)) to collect and
monitor deployed civilian's perceptions related to mental health care.

The Department recognizes that more can be discovered about deployed federal civilians'
perceptions of mental health treatment and the subsequent impacts of these perceptions on their
mental health care utilization and readiness. The means now exist for tracking which civilians
are deployed and work is underway to automate the collection of this information. Unlike the
situation with our active duty Service members, DoD cannot require that a deployed civilian seek
care, or that a civilian participate in a DoD survey. It is important to note, however, that federal
civilian employees are required to meet the same medical standards as Service members for
deployment (DoD Instruction 6490.07, "Deployment-Limiting Medical Conditions for Service
Members and DoD Civilian Employees").

DoD RESPONSE: DoD concurs with comment, as stated above.

RECOMMENDATION 2: The GAO recommends that the SecDef direct the USD(P&R) to
leverage recommendations made by RAND Corporation in its 2014 report on mental health
stigma in the military to update and clarify policies as needed to remove stigmatizing provisions,
such as career restrictions that may be too limiting for individuals who have received mental
health care.

COMMENT: None.

DoD RESPONSE: The DoD concurs without comment.

RECOMMENDATION 3: We recommend that the SecDef direct the USD(P&R) to take the
following action: establish a clear, consistent definition of those barriers to care generally
understood by DoD as "mental health care stigma," to include such explanations of causes or
contributing risk factors and ways that stigma is apparent in behaviors and policies.

COMMENT: The DoD agrees that focusing on stigma-associated barriers to seeking care is the
most fruitful way ahead in improving DoD's ability to target our efforts and to consistently
measure the impact of those efforts.

DoD RESPONSE: The DoD concurs with comment, as stated above.

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RECOMMENDATION 4: We recommend that the SecDef direct the USD(P&R) to take the following action: establish goals for efforts to address barriers to mental health care generally understood as "stigma reduction efforts" and performance measures that link to these goals.

COMMENT: As discussed, the relationship between an individual's perception of stigma and health seeking behavior is a complex one. The DoD will continue its efforts to identify those perceptions critical to health seeking behaviors and to measure our success in increasing Service members' willingness to seek and continue care.

DoD RESPONSE: The DoD concurs with comment, as stated above.

RECOMMENDATION 5: The GAO recommends that the SecDef direct the USD(P&R) to develop a method to collect and analyze information on barriers to seeking mental health care, including stigma, so that reliable data may be gathered and used to measure the effectiveness of stigma reduction efforts.

COMMENT: None

DoD RESPONSE: The DoD concurs, without comment.

RECOMMENDATION 6: The GAO recommends that the SecDef direct the USD(P&R) to designate an entity to coordinate efforts to reduce mental health care stigma, among other barriers to care.

COMMENT: The Department agrees that designation of an existing work group with medical, personnel, and Service stakeholders to take on this responsibility will allow this work to be accomplished via a collaborative, cross-agency approach.

DoD RESPONSE: The DoD concurs with comment as stated.

RECOMMENDATION 7: The GAO recommends that the SecDef direct the Under Secretary of Defense for Intelligence (USD(I)) to reissue consolidated guidance, incorporating subsequent updates for the denial or suspension of access to classified information and for assignment to sensitive duties based solely on information about mental health care.

COMMENT: Fulfillment of this recommendation is well underway. The USD(I) currently has new guidance which is already well advanced in the coordination and should be completed within a year.

DoD RESPONSE: The DoD concurs with comment as stated.

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Appendix VI: GAO Contact and Staff Acknowledgments

GAO Contact:	Brenda S. Farrell, (202) 512-3604 or farrellb@gao.gov
Staff Acknowledgments:	In addition to the contact named above, key contributors to this report were Lori Atkinson, Assistant Director; James Ashley, Rebecca Beale, Melissa Blanco, William Egar, Mae Jones, Felicia Lopez, Terry Richardson, Amber Sinclair, Angela Smith, and John Van Schaik.